Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, July 21, 2015 at the hour of 10:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Gugenheim called the meeting to order.

Present: Chairman Ada Mary Gugenheim and Directors Wayne M. Lerner, DPH, LFACHE and Erica E. Marsh, MD, MSCI (3)

Board Chairman M. Hill Hammock (ex-officio), Director Emilie N. Junge and Patrick T. Driscoll, Jr. (non-Director Member)

Absent: None (0)

Additional attendees and/or presenters were:

David Barker, MD – Ruth M. Rothstein CORE Center of Cook County
Krishna Das, MD – System Chief Quality Officer
Claudia Fegan, MD - Executive Medical Director/Medical Director-Stroger
Randolph Johnston – Associate General Counsel
Elizabeth Reidy – General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief Executive Officer
Mark A. Wille, MD, FACS - John H. Stroger, Jr. Hospital of Cook County

II. Public Speakers

Chairman Gugenheim asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report from Chief Quality Officer

A. Regulatory and Accreditation Updates

Dr. Krishna Das, Chief Quality Officer, stated that there were no new updates to provide regarding regulatory and accreditation matters. Staff continue their preparations for the full accreditation survey by The Joint Commission (TJC) at Stroger Hospital; the survey will occur anytime between now and November.

B. Metrics (Attachment #1)

Dr. Das reviewed the presentation on Metrics. The Committee discussed the information.

With regard to the ongoing project that addresses Operating Room efficiencies, Director Lerner asked when the team responsible for the project will be able to come to this Committee and make a presentation. Dr. Das indicated that the plan is for this to be presented in September.

Board Chairman Hammock noted that there is a difference in the data between the Board summary page and the other data; the numbers do not quite seem to track. Dr. Das stated that she will look into that question and follow up with a response.

III. Report from Chief Quality Officer

B. Metrics (continued)

During the discussion of the data on Patient Satisfaction regarding cleanliness, Board Chairman Hammock asked whether the administration has identified the particular aspects of cleanliness about which the patients are commenting. Dr. Das responded that, of the three (3) questions relating to the hospital environment, there is one (1) question regarding cleanliness. There have not been any specific locations identified, such as bathrooms, hallways, or general areas; the administration reads the comments provided by patients, and it involves all of the above. Director Lerner stated that, from his experience, it can be quite revealing and insightful to periodically do a data dump of all the open ended comments and send them to the Board Members for review; this could provide some ideas in response to the question on cleanliness.

C. Report – CORE Center / HIV Care (Attachment #2)

Dr. David Barker, Medical Director of the Ruth M. Rothstein CORE Center of Cook County, provided an overview of the presentation, which included information on the following subjects: CORE Quality Plan; CORE Patient Satisfaction Survey; CORE Return to Care Survey; CORE Outreach Efforts; Public Health Approach; Comparisons of HIV Treatment Cascades; Screening Effectiveness in CCHHS; Maintaining Early Access at CORE; Linkage to Care; Retained/Engaged in Care at CORE; Virologic Suppression Among those Engaged in Care; 2014 CORE Performance Measures; CCHHS-Wide HIV Programs; and Pre-Exposure Prophylaxis. The Committee reviewed and discussed the information.

During the discussion of the information regarding HIV testing at CCHHS, Dr. Barker noted that, in 2011, a pop-up reminder rule about HIV testing was instituted in the electronic medical record. This led to a big increase in testing in 2012 and 2013; however, in 2014, a substantial decline in testing was seen. In some cases, the patient will refuse the test, or the staff is unable to get the patient's consent (example: trauma cases). In order to not test someone, one has to actively turn off the pop-up window. He noted that, at Stroger Hospital's Emergency Room, one-third of the patients have their blood tests ordered by the nurses at the front end, as a protocol. The administration needs to work on getting the pop-up window to occur at that point, and also to get it in all of the nurses' protocol orders.

D. Report – Illinois Surgical Quality Improvement Collaborative (ISQIC) (Attachment #3)

Dr. Claudia Fegan, Executive Medical Director/Medical Director-Stroger, provided an introduction to the subject. Dr. Mark A. Wille, Attending Physician (Urology) at John H. Stroger, Jr. Hospital of Cook County, provided an overview of the report on the Illinois Surgical Quality Improvement Collaborative (ISQIC). Included in the presentation was information on the following subjects: Overview of ISQIC; Objective; Hospitals Involved; Responsibilities of CCHHS; ISQIC Team; Key Features; Comparative Reports; Cost Savings/ Return on Investment; Example of Successful Surgical Quality Collaboratives; Resources to Facilitate Improvement; Funding; and Accomplishments to Date. The Committee reviewed and discussed the report.

IV. Action Items

A. Executive Medical Staff (EMS) Committees of Provident Hospital of Cook County and John H. Stroger, Jr. Hospital of Cook County

i. Receive reports from EMS Presidents

There were no reports provided at this time.

ii. Approve Medical Staff Appointments/Re-appointments/Changes (Attachment #4)

Director Lerner, seconded by Director Marsh, moved to approve the Medical Staff Appointments/Reappointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

B. Minutes of the Quality and Patient Safety Committee Meeting, June 16, 2015

Chairman Gugenheim, seconded by Director Marsh, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of June 16, 2015. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections IV and V

V. Closed Meeting Items

A. Medical Staff Appointments/Re-appointments/Changes

B. Litigation Matter(s)

Director Lerner, seconded by Director Marsh, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," 5 ILCS 120/2(c)(**11**), regarding "litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting," and 5 ILCS 120/2(c)(**17**), regarding "the recruitment, credentialing, discipline or formal peer review of physicians or other health care professionals for a hospital, or other institution providing medical care, that is operated by the public body." THE MOTION CARRIED UNANIMOUSLY.

Chairman Gugenheim declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

VI. Adjourn

As the agenda was exhausted, Chairman Gugenheim declared the meeting ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXX
Ada Mary Gugenheim, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
July 21, 2015

ATTACHMENT #1

COOK COUNTY HEALTH & HOSPITALS SYSTEM

CCHHS Board of Directors
Quality and Patient Safety Committee
Dashboard Overview

21 July 2015

Krishna Das, MD, Chief Quality Officer

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Dashboard Overview

- Quality measures – process, outcome and efficiency
- Safety measures
- Patient satisfaction
- Hospitals and ambulatory are included

Quality – Stroger

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015	CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015			
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Core Measures															
Venous Thromboembolism (VTE) Prevention (%)	85	81	92	84	88	87	83	84	79	92	79	86	91	99	-8%
Care for Stroke Patients (%)	94	95	95	97	96	97	93	91	96	93	92	87	91	100	-9%
Influenza and Pneumococcal Vaccination (%)	59	45	47	53	62	74	68	68	66	67	64	36	48	90	-42%
Efficiency - Operating Room															
Surgery Begins at Scheduled Time (%)	38	48	38	41	32	35	45	35	30	47	62	56	52	80	-28%
OR Room Turn Around Time (minutes)	52	49	51	48	54	57	54	50	51	45	45	43	45	35	-10%

Quality – Provident

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015	CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015			
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Core Measures															
Venous Thromboembolism (VTE) Prevention (%)	96	91	85	95	95	86	100	82	94	100	100	95	91	99	-8%
Influenza and Pneumococcal Vaccinations (%)	80	82	64	77	62	78	71	89	93	79	95	93		90	3%
Efficiency - Operating Room															
Surgery Begins at Scheduled Time (%)		5	25	14	10	13	28	15	19	12	17	45	70	80	-10%
OR Room Turn Around Time (minutes)														35	na

Safety – Stroger

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015	CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015			
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Safety															
HAC: Pressure Ulcer Stages III & IV[1]	4	2	0	0	2	2	4	4	2	5	2	2	6		
HAC: Falls with Injury[2]	0	1	1	1	0	0	0	0	1	0	0	3	3		
HAI: CLABSI [3]	1	1	0	0	0	0	0	0	2	3	0	1	3		
HAI: CAUTI [4]	1	1	1	1	1	1	0	0	0	0	0	0	0		

LEGEND
CLABSI: Central line-associated blood stream infections
CAUTI: Catheter-associated urinary tract infections
*Variance is target to recent full quarter

Patient Experience – Stroger

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015	CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015			
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Patient Experience															
Willing to Recommend Hosp (% top box)	60	61	70	69	66	65	71	71	73	66	60	71	71	85	-14%
Communication with Doctors (% top box)	77	78	84	84	83	78	86	84	87	82	78	85	85	88	-3%
Communication with Nurses (% top box)	60	70	68	70	70	65	74	75	74	67	68	75	73	86	-13%
Cleanliness (% top box)	44	51	57	52	49	52	43	50	57	49	42	57	48	77	-29%

Patient Experience – Provident

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015	CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015			
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Patient Experience															
Willing to Recommend Hosp (% top box)	48	56	54	59	84	69	50	70	73	67	70	69	75	85	-10%
Communication with Doctors (% top box)	97	85	85	85	72	95	74	81	82	92	93	82	75	88	-13%
Communication with Nurses (% top box)	84	70	81	85	75	88	67	84	77	92	87	92	75	86	-11%
Cleanliness (% top box)	62	75	69	52	53	64	69	65	87	62	50	42	75	77	-2%

ACHN

CCHHS QPS Committee Dashboard															
Data as of 07/13/2015	CY 2014								CY 2015					TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2014		Q3 2014			Q4 2014			Q1 2015			Q2 2015			
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
ACHN															
Diabetes Control % with Hgb A1C < 9%	73		77			78			74	73	73	73	74	78	-4%
Immunizations: Up to date in children at 24 months (%)	87		57			68			60	49	58	81	66	86	-20%
Patient Experience: Moving Through Visit	68		68			67			65	68	67	68	59	75	-16%
Patient Experience: Telephone Access	60		63			62			70	53	64	64	57	75	-18%

Board Quality Dashboard

CCHHS QPS Committee Dashboard	CCHHS Board Metrics - Quality							
Data as of 07/13/2015								
PERFORMANCE MEASURES	CY 2014			CY 2015				
					2Q15		TARGET	VARIANCE*
	2Q14	3Q14	4Q14	1Q15	Apr	May		
Stroger								
Core Measures	**Monthly Composite**							
Venous Thromboembolism (VTE) Prevention (%)	80	88	85	83	84	91	99%	-8%
Efficiency - Operating Room	**Monthly %**							
Surgery Begins at the Scheduled Time (%)	44	37	38	46	56	52	80%	-28%
Safety	**Total # of Events**							
Events: Ulcers, Falls, CLABSI and CAUTI	29	26	13	22	6	12		
Patient Experience								
Willing to Recommend Hosp (% top box)	62	68	69	66	71	71	85%	-14%
Provident								
Core Measures								
Venous Thromboembolism (VTE) Prevention (%)	90	92	89	98	95	91	99%	-8%
Efficiency - Operating Room	**Monthly %**							
Surgery Begins at the Scheduled Time (%)	44.3	37	38	16	45	70	80%	-10%
Patient Experience								
Willing to Recommend Hosp (% top box)	56	66	63	70	69	75	85%	-10%
ACHN								
Diabetes Control % with Hgb A1C < 9%	73	77	78	73	73	74	78%	-4%
Patient Experience: Moving Through Visit	68	68	67	67	68	59	75%	-16%
Patient Experience: Telephone Access	60	63	62	62	64	57	75%	-18%

LEGEND
CLABSI: Central line-associated blood stream infections
CAUTI: Catheter-associated urinary tract infections
*Variance is target to recent full quarter

Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
July 21, 2015

ATTACHMENT #2

July 2015
Quality and Patient Safety Committee Report

Dave Barker, MD, MPH – CORE Chief Medical Officer
Jennifer Catrambone – CORE Director of QI and Evaluation
Stephon Effinger - CORE Patient Information Coordinator
Ron Lubelchek MD – CORE Associate Medical Director

CORE Quality Plan

- Understand how our patients feel about how we serve them, – CORE Patient Satisfaction Survey
- Evolve toward the metrics of the National HIV/AIDS Strategy
  - Treatment cascade as promoted by the CDC / IOM / CMS / NHAS
  - Large scale – public health approach to HIV Care
  - Emphasis on HIV testing within CCHHS
- Ensure timely access to the services we provide
- Measure Outcomes and Processes that matter
  - HRSA / HAB / HIVQual measures
  - Primary Care Measures
- Pre-Exposure HIV Prophylaxis

eDocuments as appendices

- CORE QA Plan
- 2015 CORE Patient Satisfaction Survey (PSS)
- How CORE PSS differs from Press-Gainey
- CORE Patient Satisfaction Survey 2014
  - including departmental modules
- Results of CORE Return to Care Survey 2014

Ruth M Rothstein CORE Center - Patient Satisfaction Survey - 2015

Please think about your visits to CORE over the last 12 months when you answer these questions. Your responses will be kept private, so please be honest!

- Use a No. 2 pencil or a blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the response completely.
- Make no stray marks on this form.

CORRECT: ● **INCORRECT:** ⊘ ⊗ ◒ ◔

1. **I have received medical care here for...**
   (1) less than 1 year (2) 1-2 years (3) 3 to 5 years (4) more than 5 years

2. **I would rate my health today as...** (5) excellent (4) very good (3) good (2) fair (1) poor

3. **My last visit here was...** (1) less than 1 month ago (2) 1-2 months ago (3) 3-6 months ago (4) more than 6 mos. ago

Access to HIV Care (in the last 12 months...)

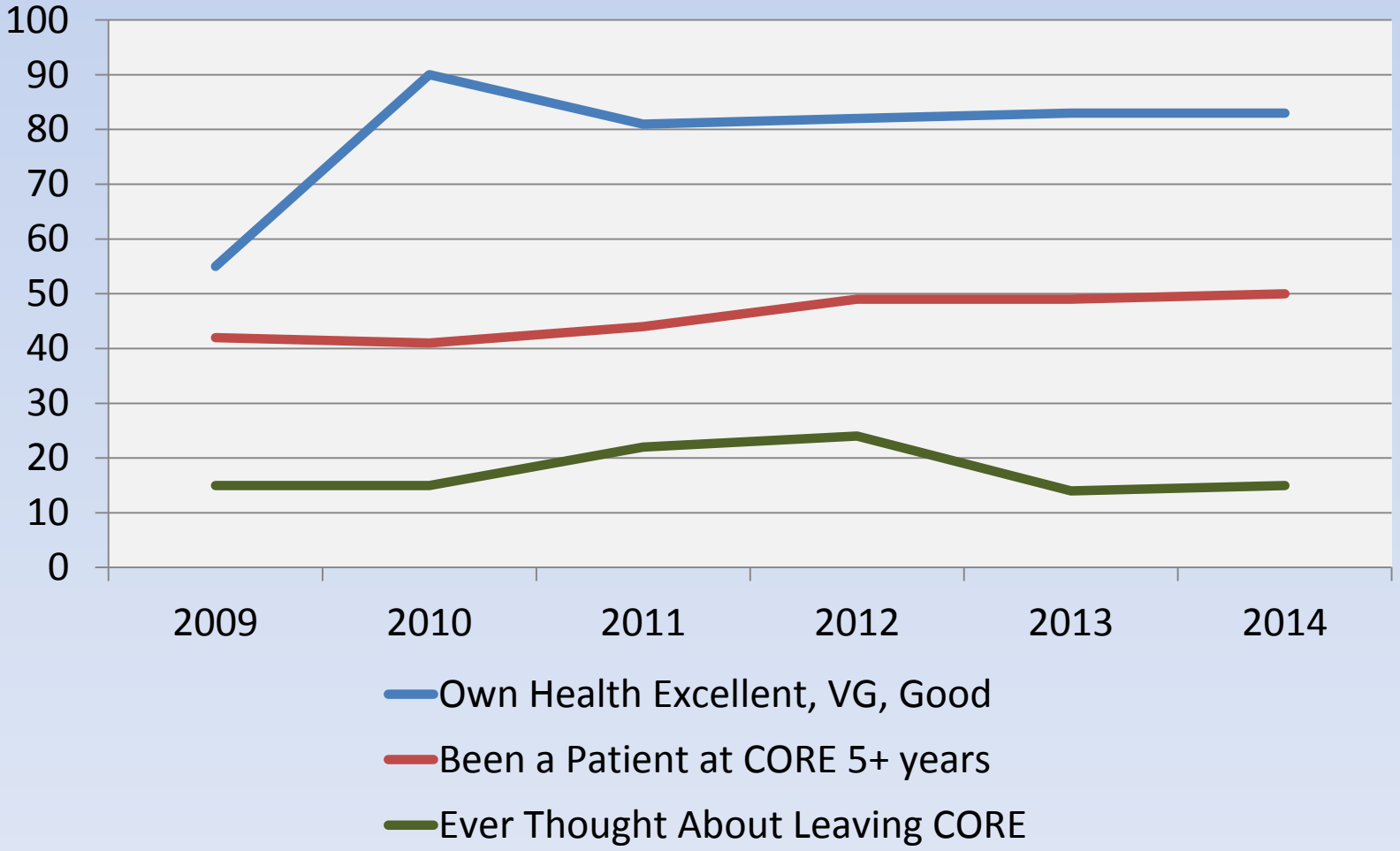
4. **Did you ever call CORE to make an appointment or talk to someone about your care?** (1) yes (2) no

5. **If yes, what was it like when you called the clinic? (please select all that apply)**
   (1) I got the help I needed
   (2) I got a busy signal or was disconnected
   (3) I was put on hold too long
   (4) I left a message and no one called me back
   (5) The phone rang many times before it was answered
   (6) The person who answered the phone was unfriendly
   (7) I talked to several different people before talking to the right person

	all the time	most times	un-decided	rarely	never	NA
6. When I needed an appointment, I could schedule one soon enough for my needs.	(5)	(4)	(3)	(2)	(1)	(NA)

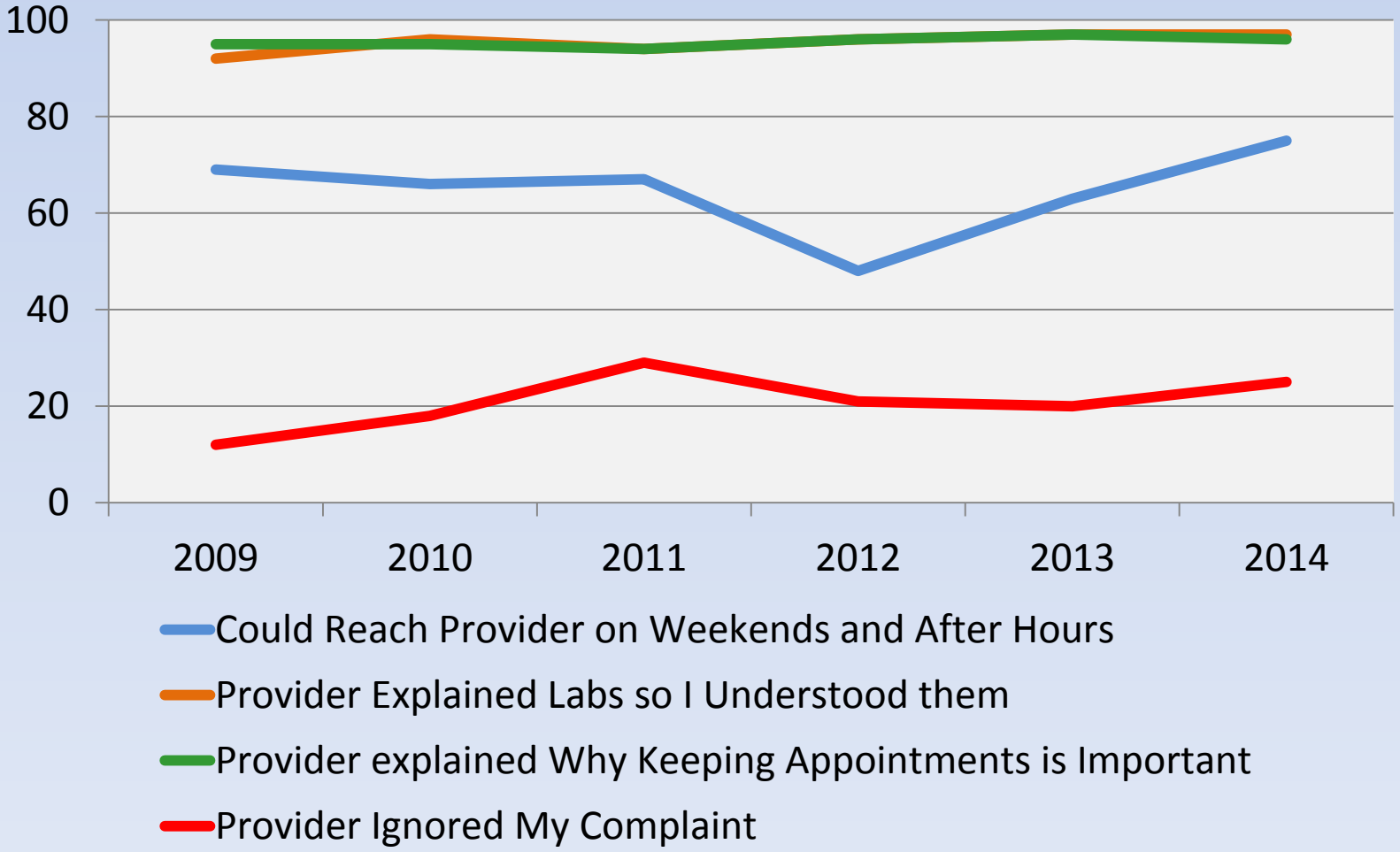
CORE Patient Satisfaction Survey – 2009 - 2014

Overall n=380 for 2014

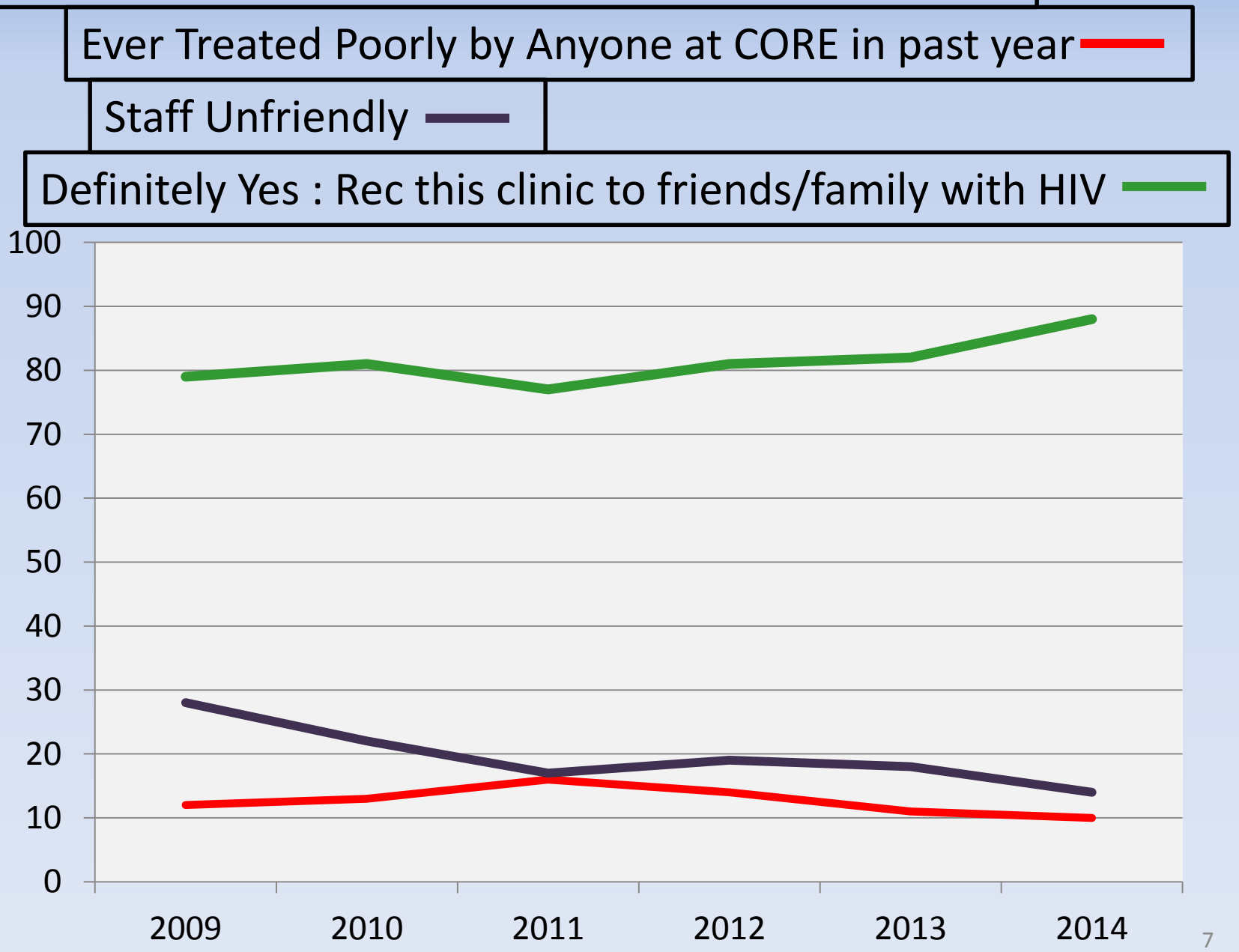


CORE Patient Satisfaction Survey – 2009 - 2014Q1

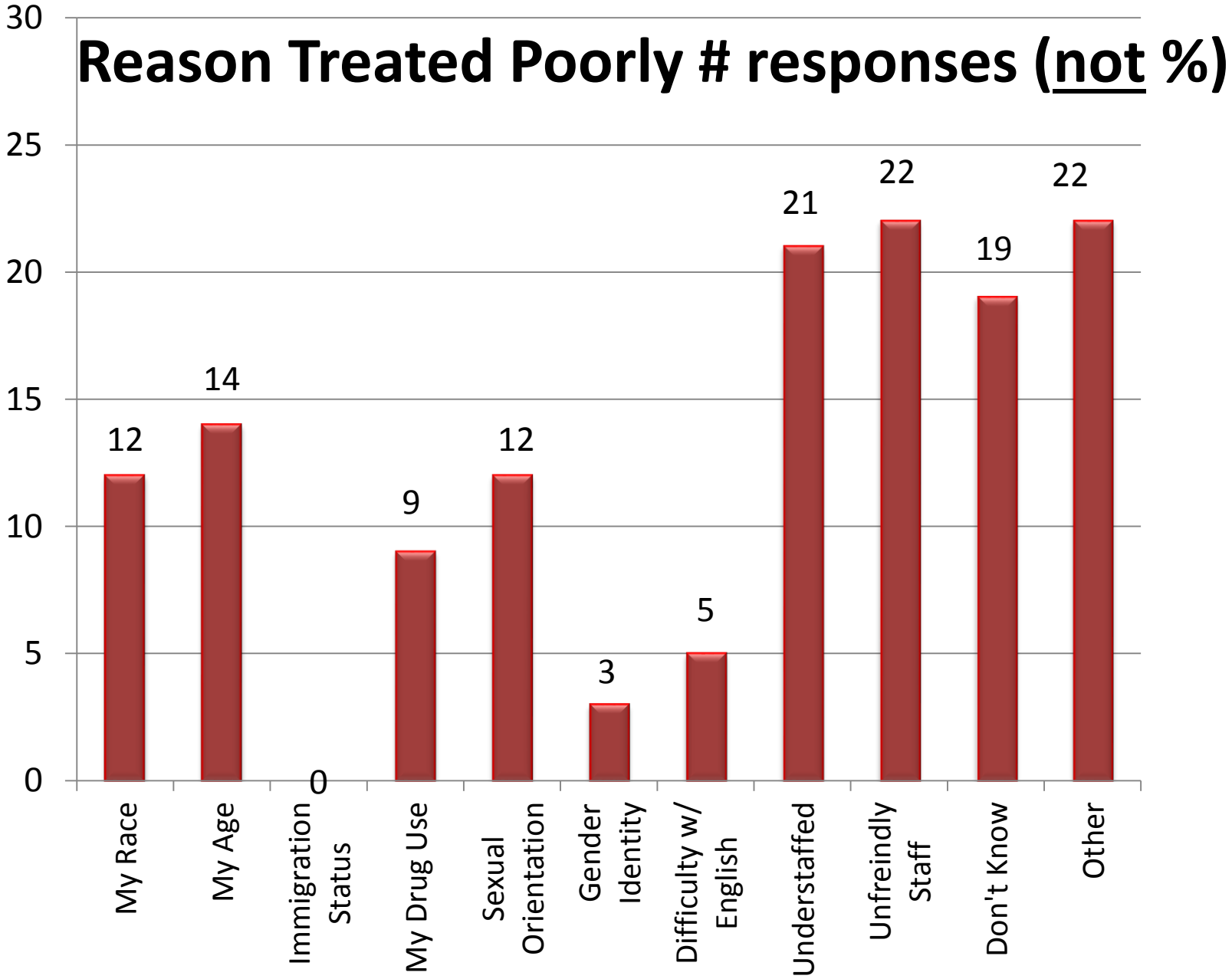
Providers



CORE Patient Satisfaction Survey – 2009-2014

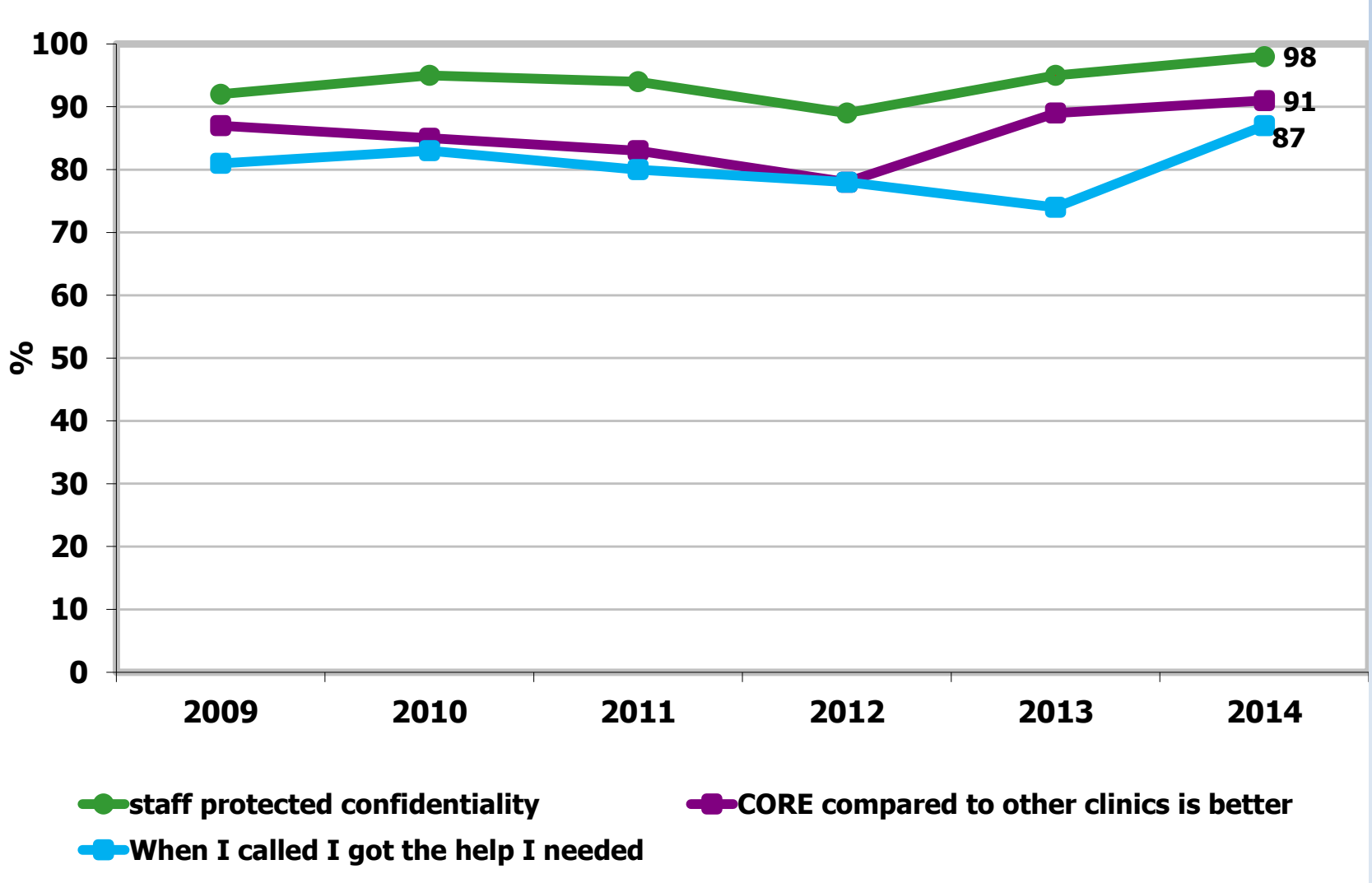


Ever Treated Poorly by Anyone at CORE in past year



CORE Patient Satisfaction Survey – 2009 - 2014

Overall

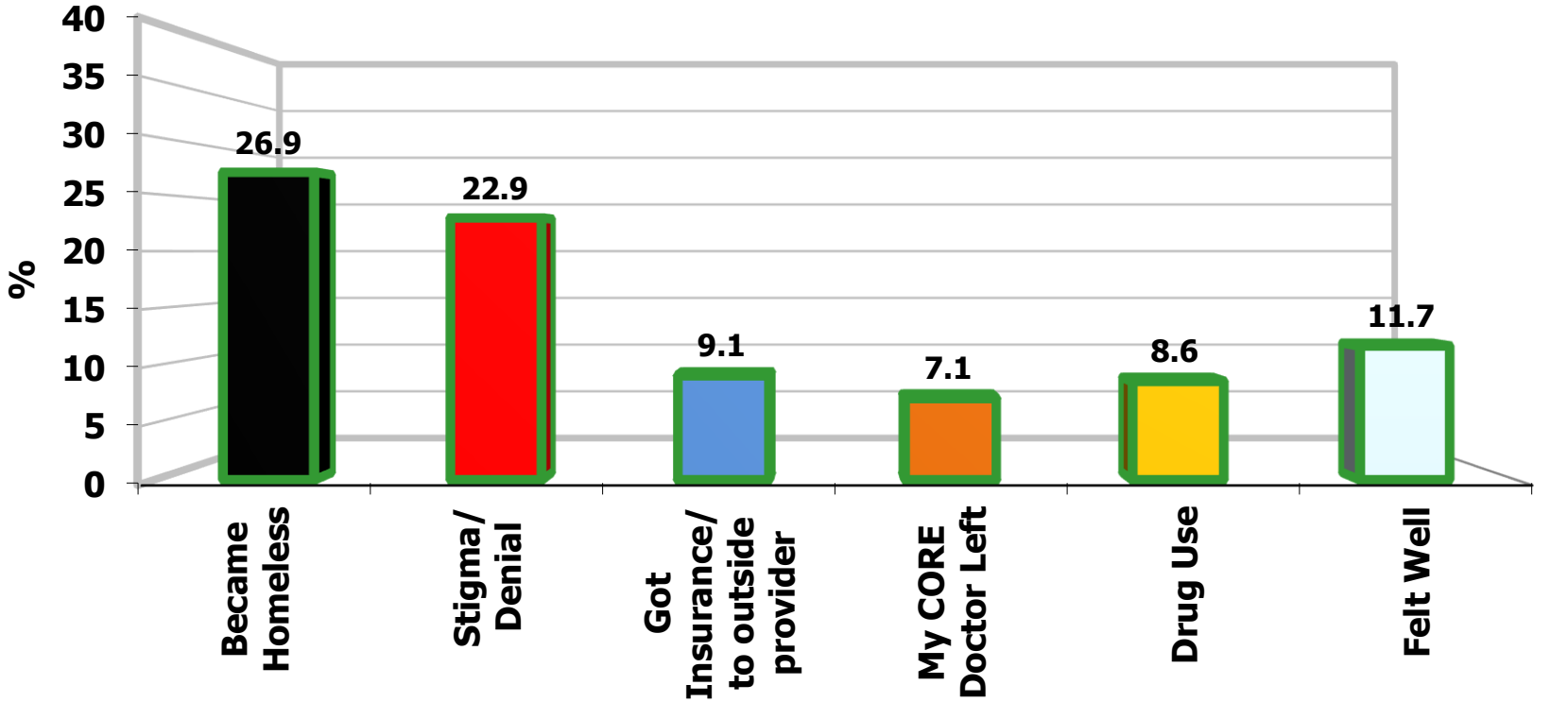


Over 90% of our patients report…

- Being able to get appointments soon enough for their needs
- Feeling involved in their health care decisions
- Being able to get their referrals
- Feeling their confidentiality is protected

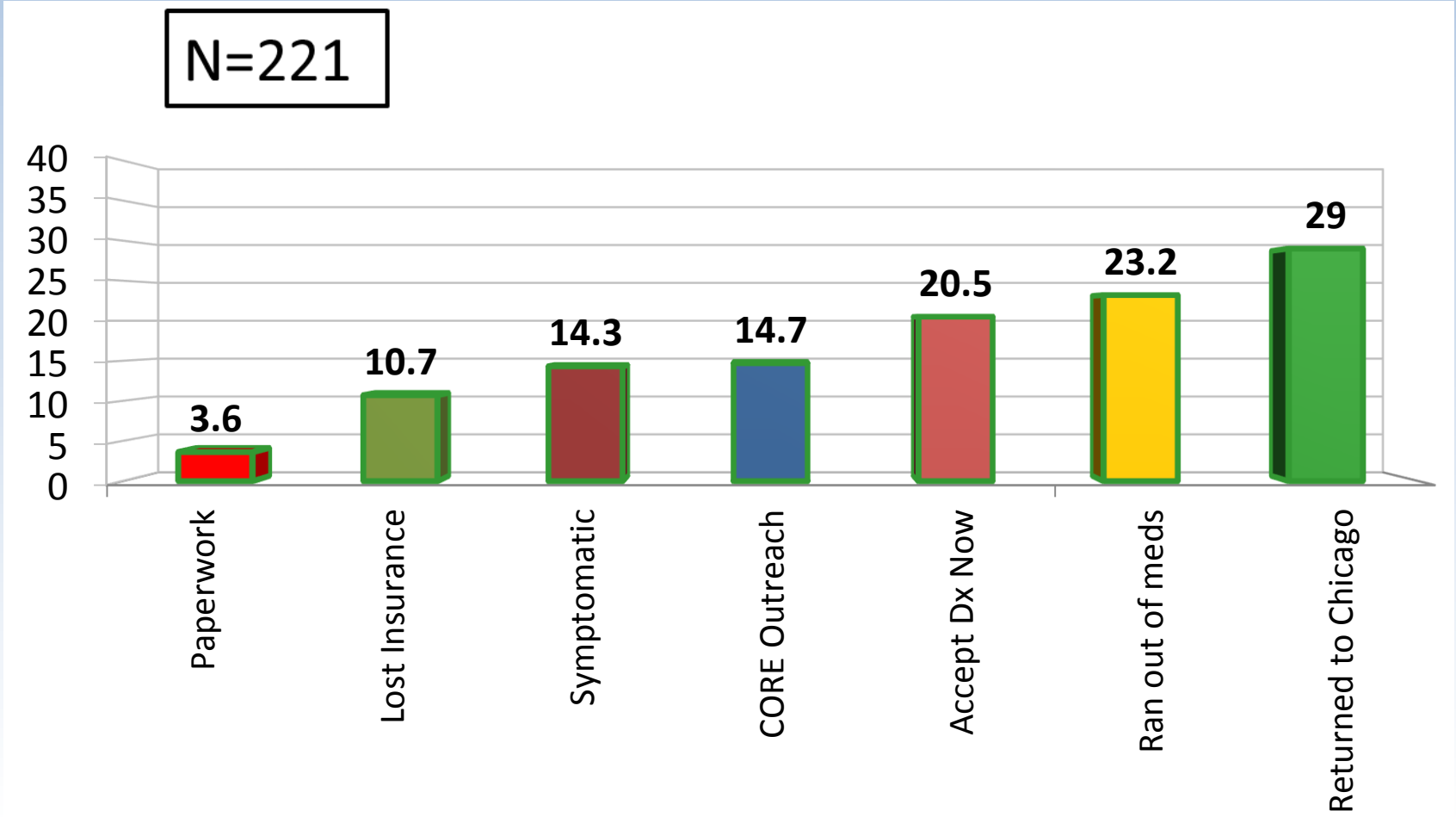
2014 CORE Return to Care Survey
top 3 reasons for leaving (patient gone >1 yr)

N=221

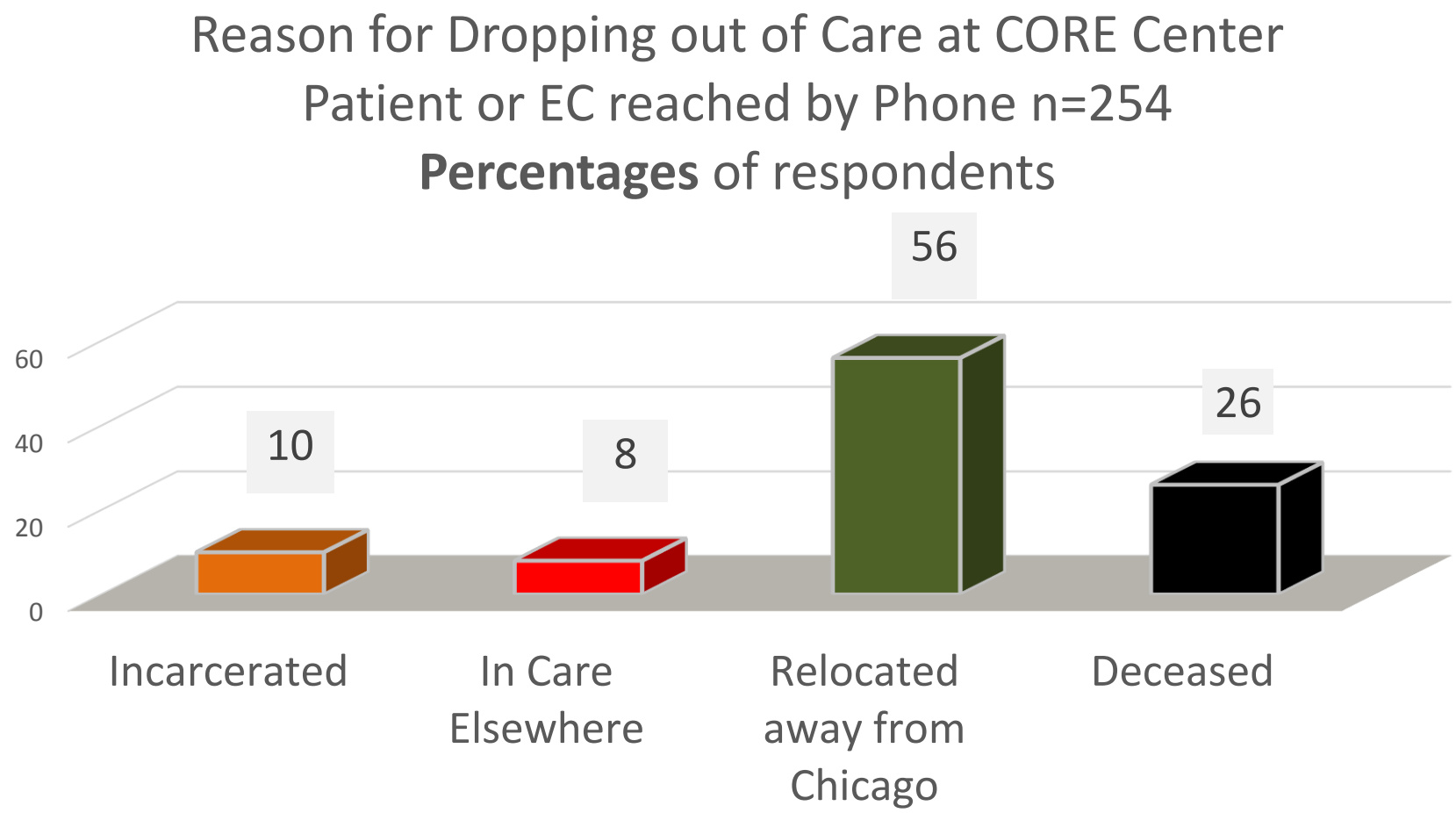


Notably not on this list: “Was Poorly Treated at CORE” 0.5% and “Clinic Schedule Not Convenient” at 4.1%

CORE Return to 2014 Care Survey
Top 3 reasons for ***returning***



CORE Outreach Efforts
In 2014, patients not seen in 6-12mo



Public Health Approach

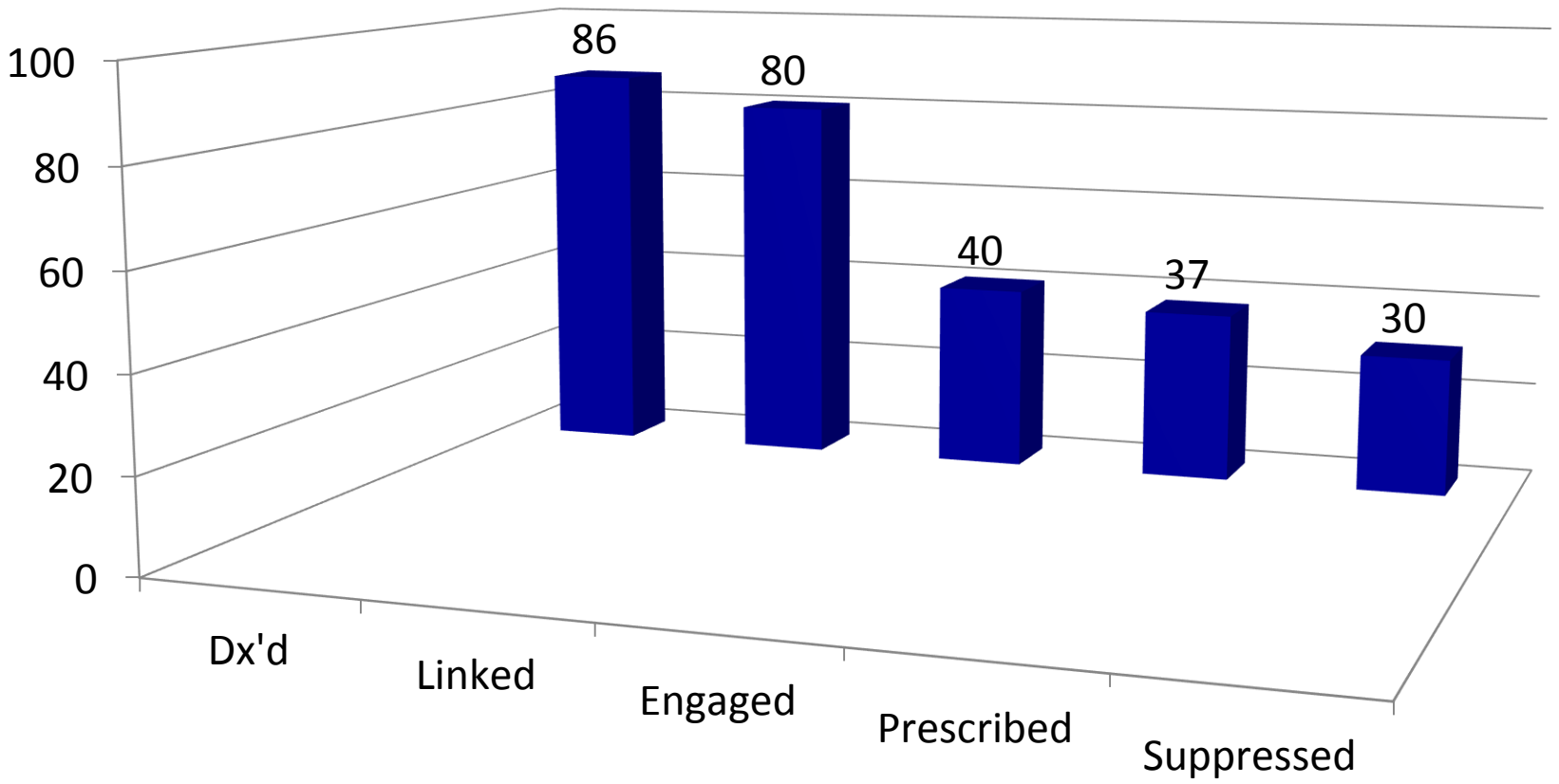
- CORE is by far largest single provider and CCHHS largest system.
- Promote widespread routine testing for HIV in CCHHS and partners – down to provider level?
- Maintain easy Access to HIV Clinics
- Outreach to newly diagnosed, linkage to care (affected by change in CDPH model for Outreach vs. EIS)
- Evolution to Patient Centered Medical Home to improve retention in Care
- Measure virologic suppression as community viral load and provider specific outcome.

WHO (proposed) Ambitious approach for 2020 is 90/90/90

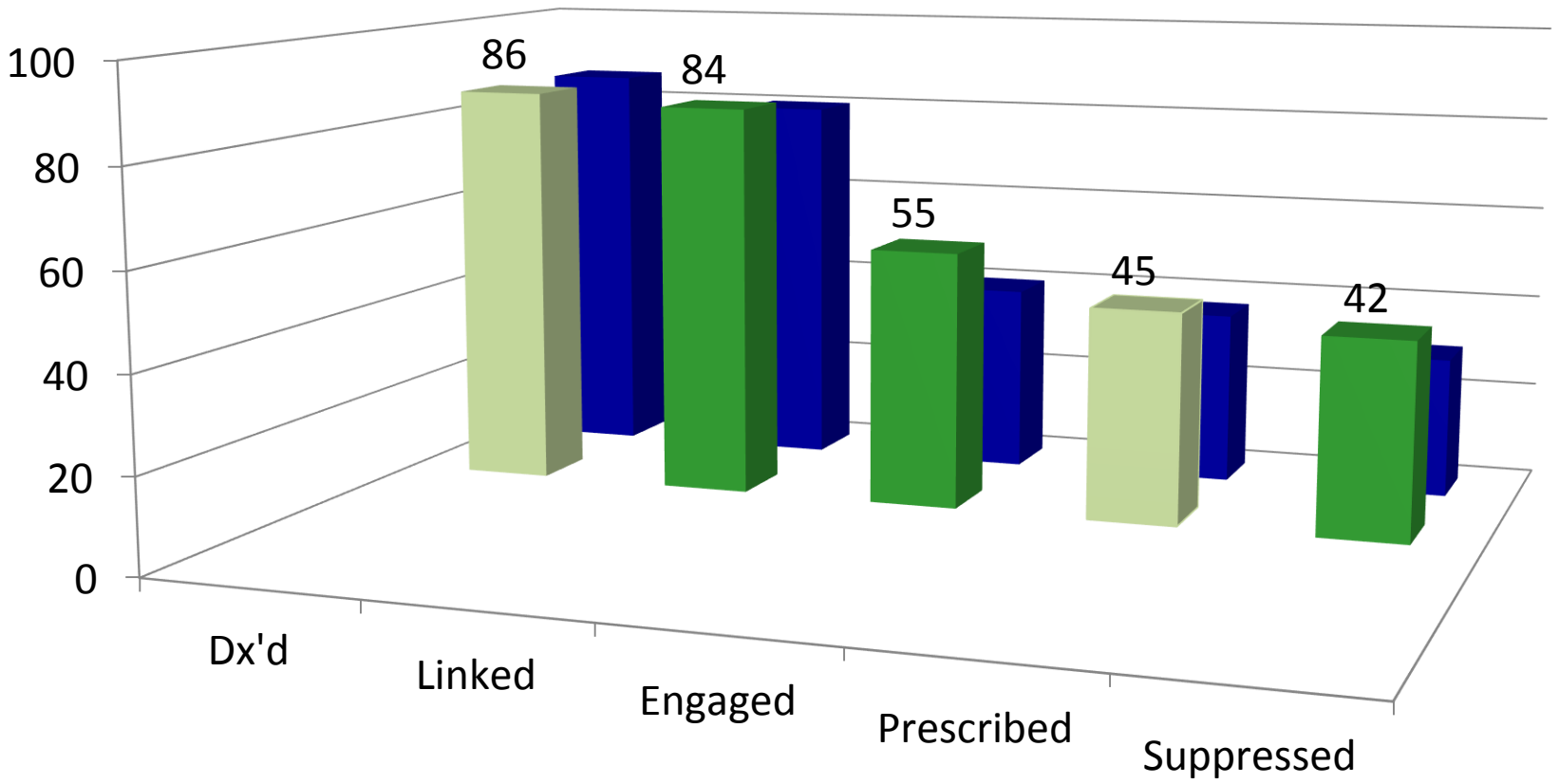
- 90% of people with HIV have been diagnosed
- 90% of those are in care
- 90% of those in care are suppressed

- In CCHHS we are at 86%+ dx'd (estimated)
- Of those 78% are engaged in Care
- Of those 86% are suppressed

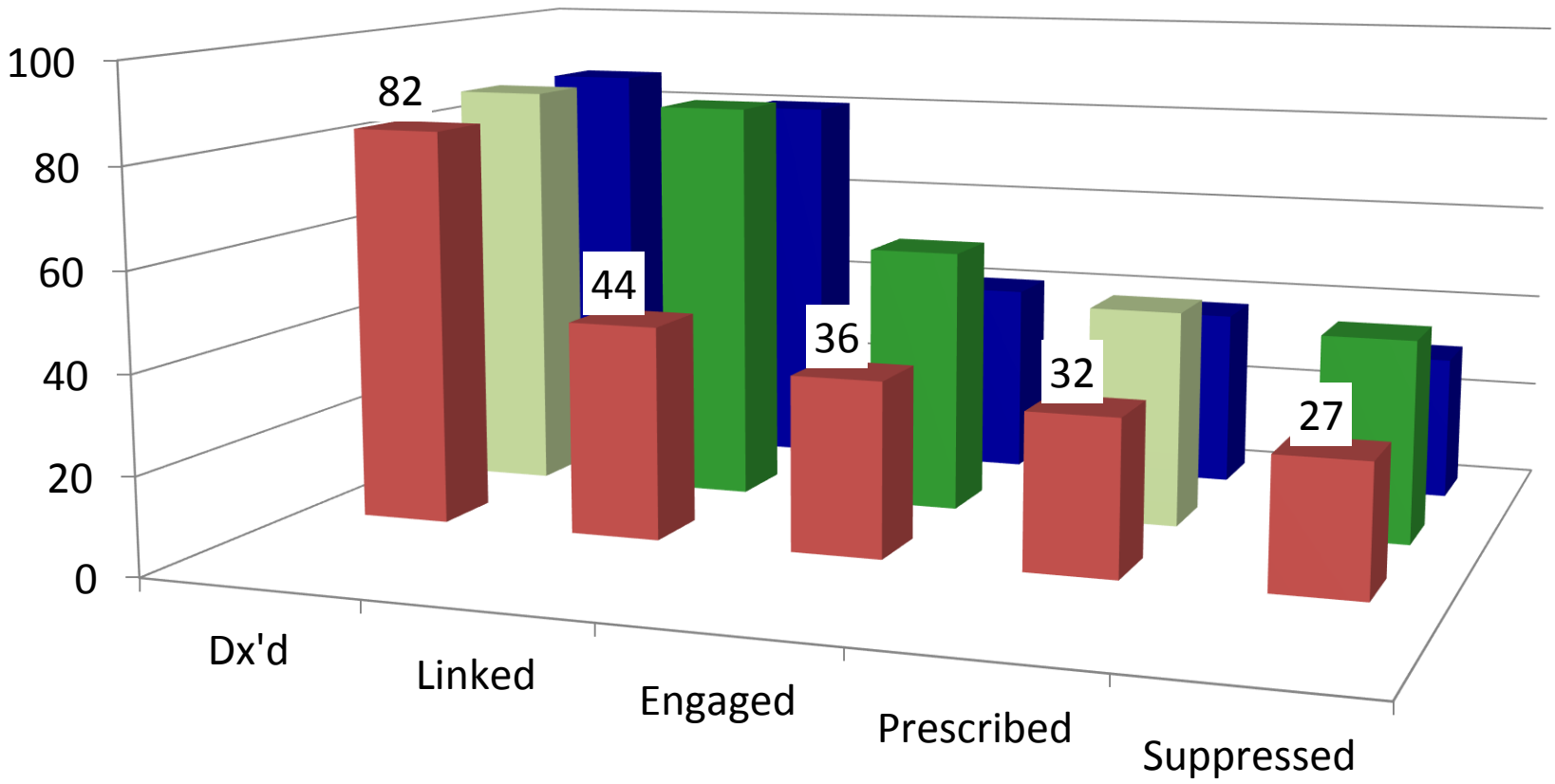
CDC HIV Treatment Cascade (2011) Entire United States



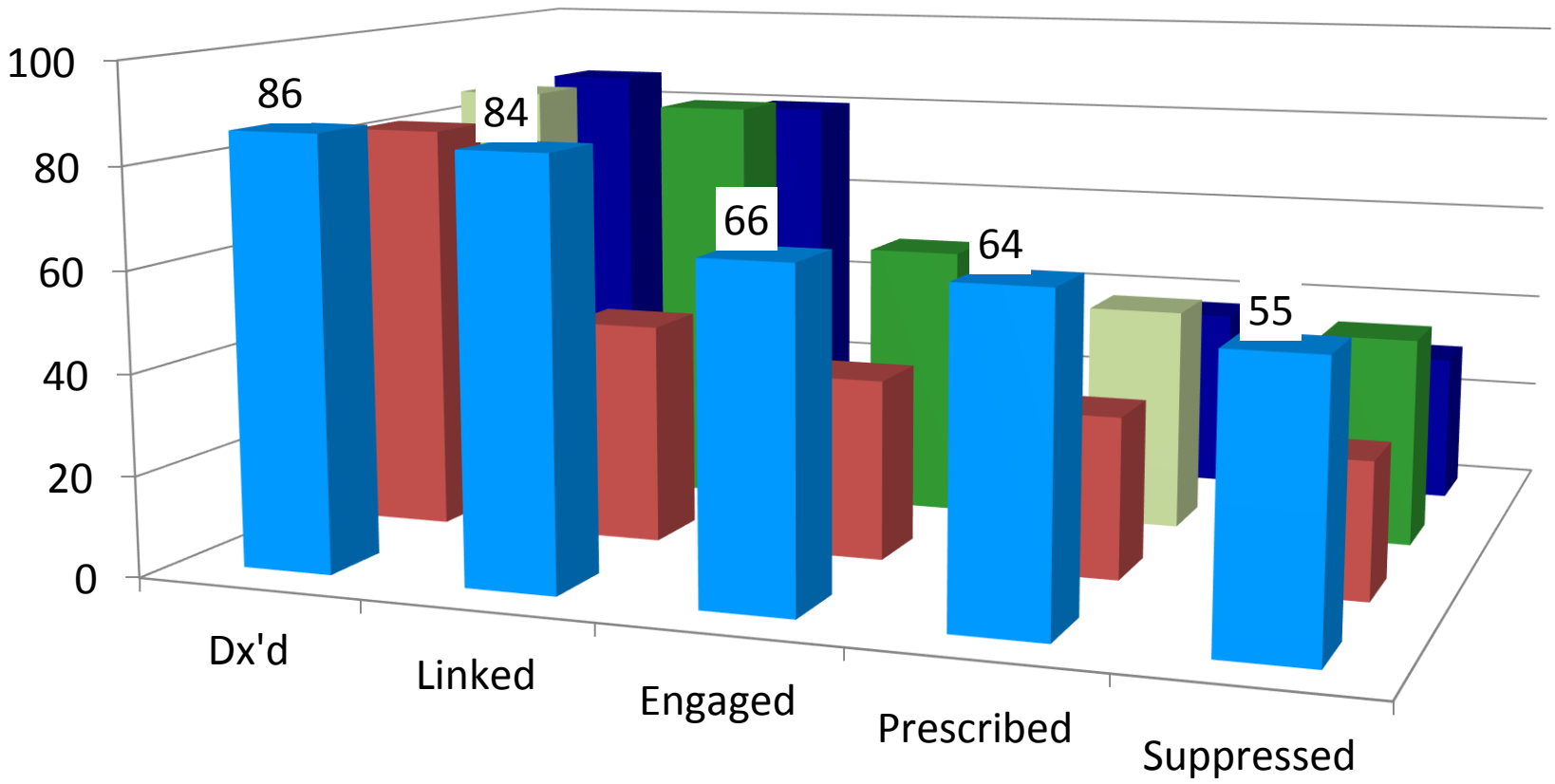
CDC/US 2011, IDPH 2013



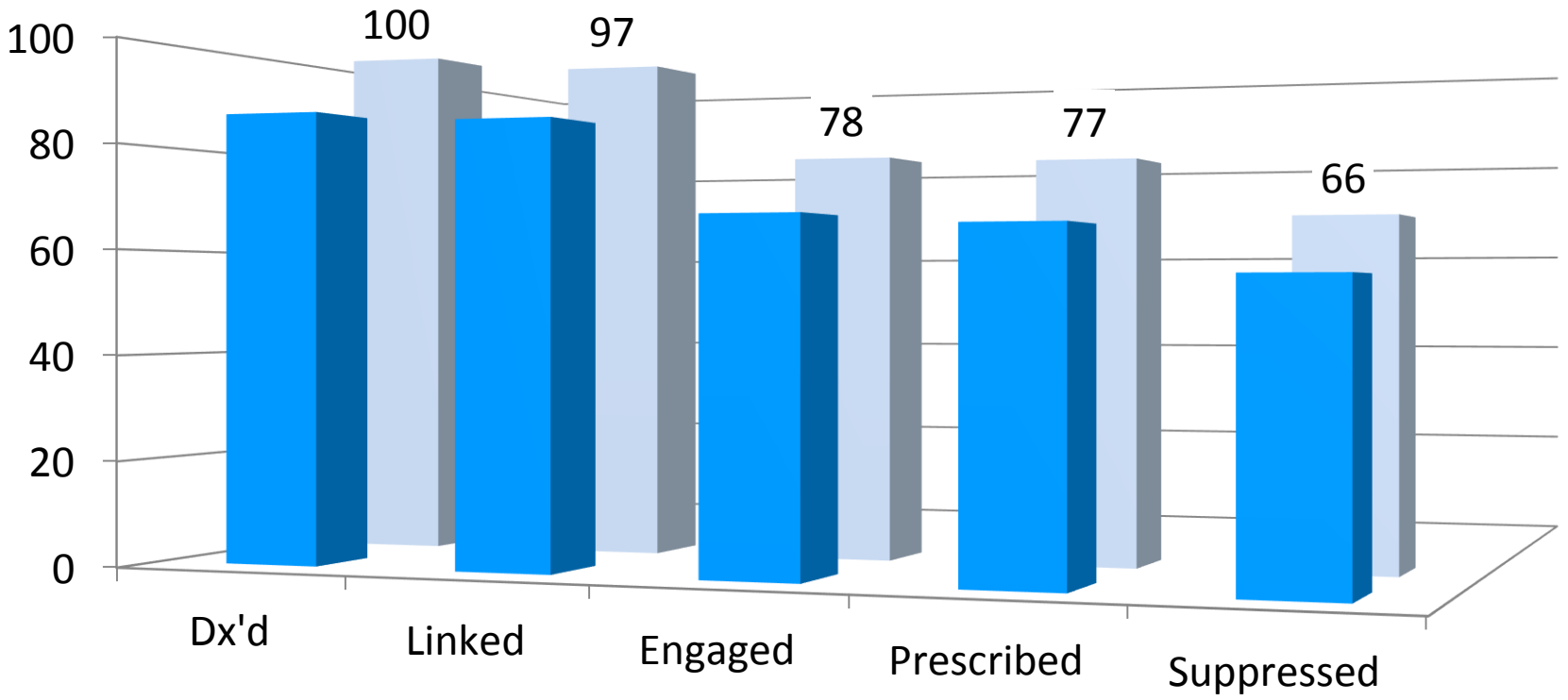
CDC/US 2011, IDPH 2013, CDPH 2011



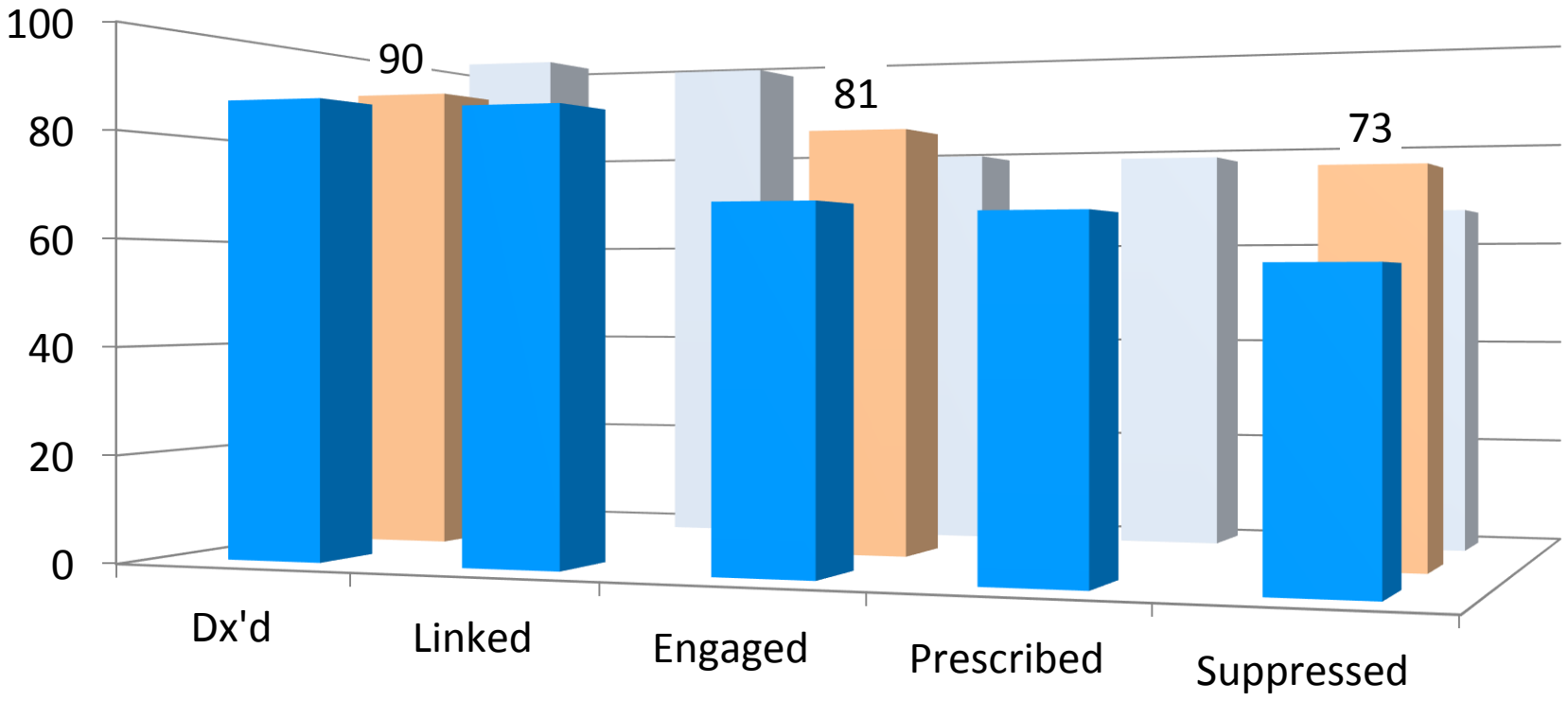
CDC/US 2011, IDPH 2013, CDPH 2011, CORE 2014



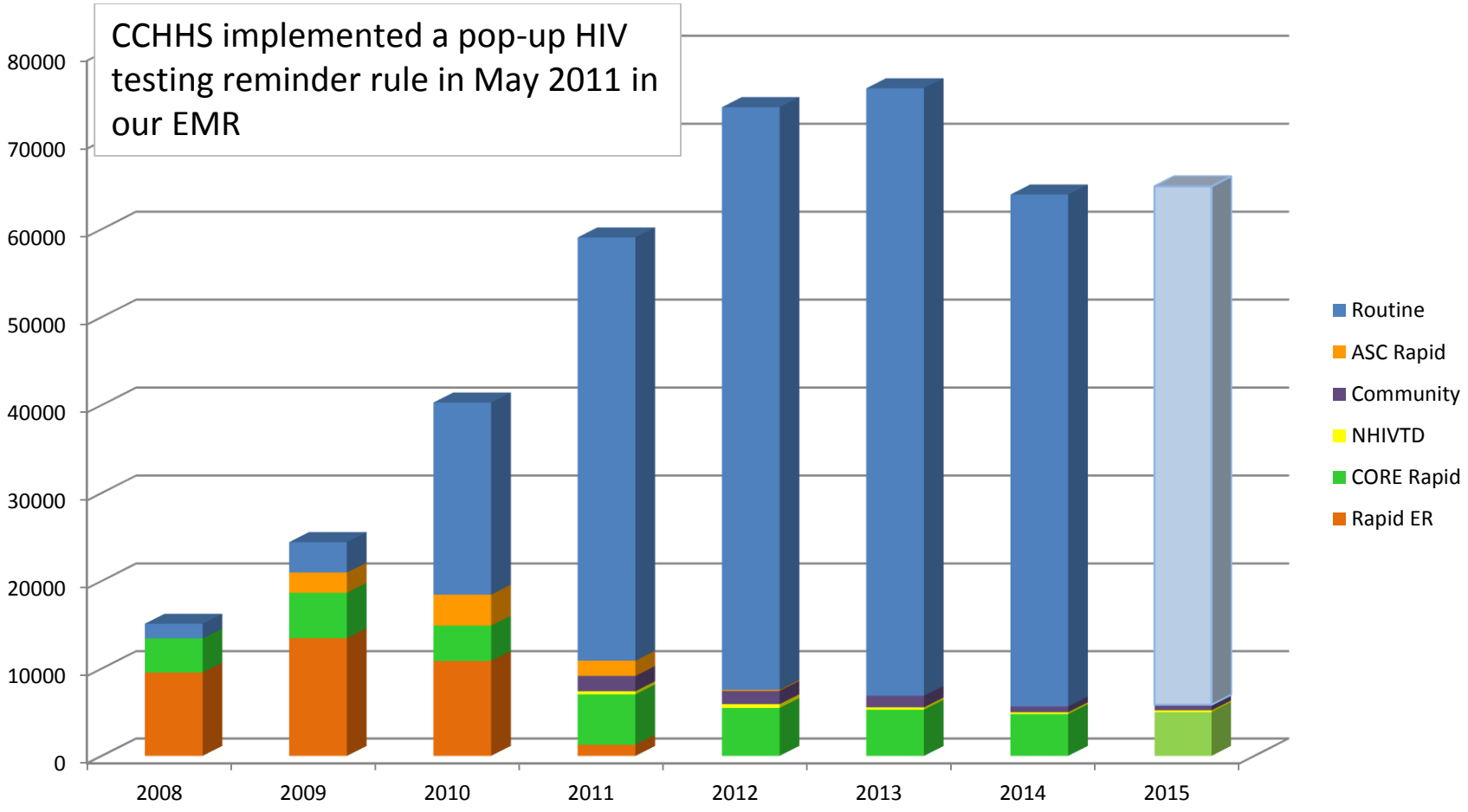
CORE by Cascade
vs. CORE if 100% diagnosed



CORE Cascade
vs. WHO 90/90/90 for 2020



Total HIV tests CCHHS incl. 2015 projection

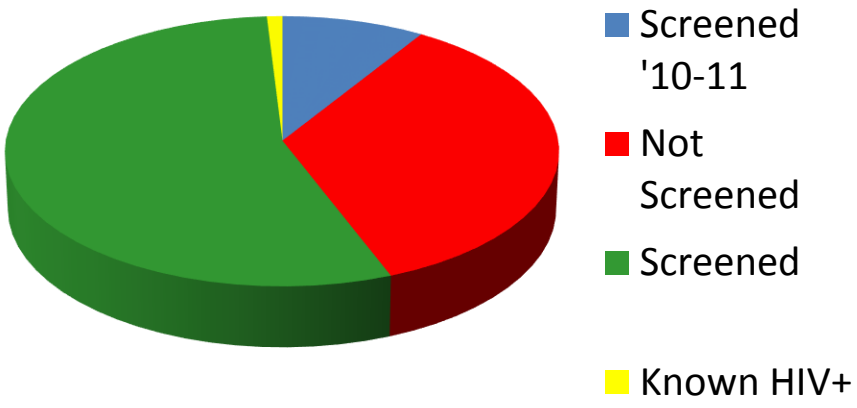


Screening Effectiveness in CCHHS

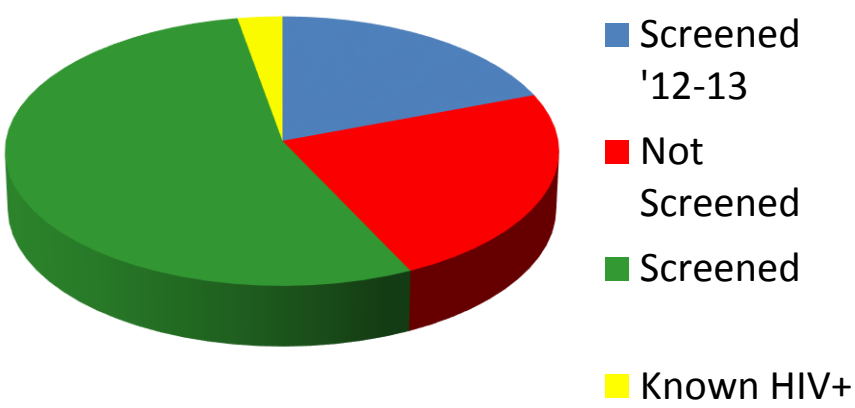
- Why did testing decline in 2014?
  - Providers burned out on testing?
  - Higher proportion of patients tested in past 2 years (reaching saturation)?
- Lab based QA
  - Total patients who had at least one blood test done in 2012 and 2014 per care venue within CCHHS (e.g. ER)
  - %who had HIV test in prior 2 years (2010-2011 and 2012-2013)
  - %who had test done this encounter
  - %known to be HIV positive
    - This mimics the logic of HIV Reminder Pop-up Rule

SHCC Inpt. Fraction not screened decreased from 35% to 24%

2012 SHCC Inpatient

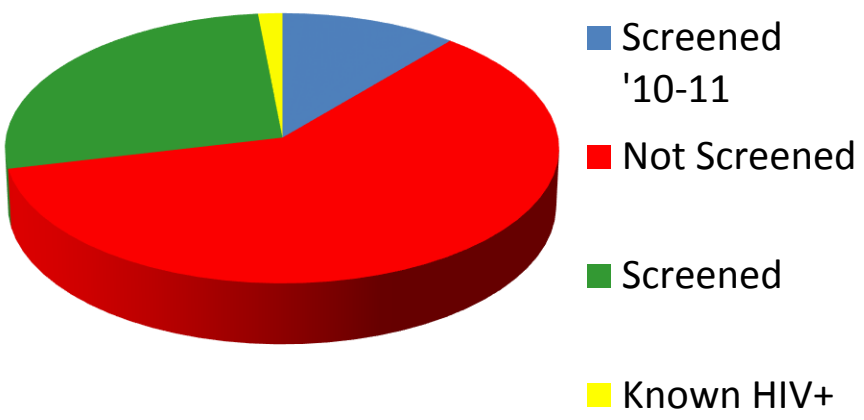


2014 SHCC Inpatient

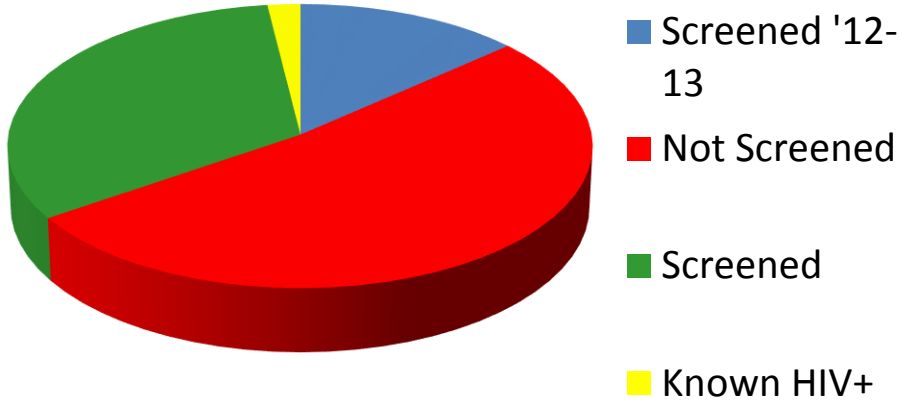


SHCC ER Fraction not screened decreased from 60% to 52%

2012 SHCC ER

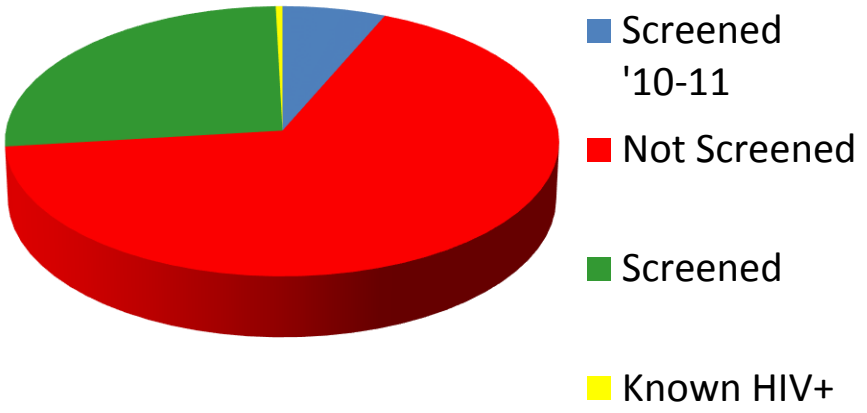


2014 SHCC ER

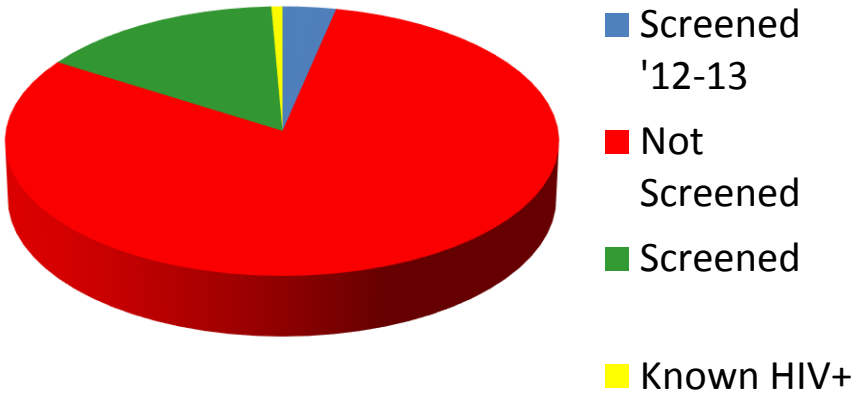


PHCC ER Fraction not screened ***Increased*** from 67% to 81%

2012 PHCC ER



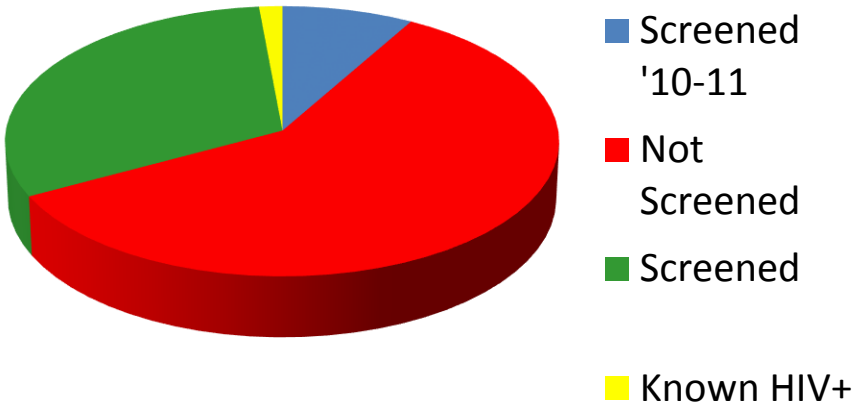
2014 PHCC ER



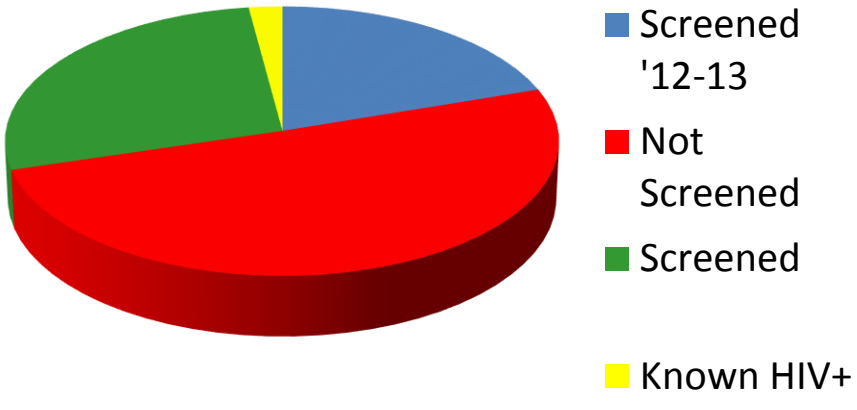
Amended data to include rapid testing by PHCC HIV Clinic staff that is not included in the Lab Info System.

ACHN Fraction not screened decreased from 58% to 51%

2012 ACHN

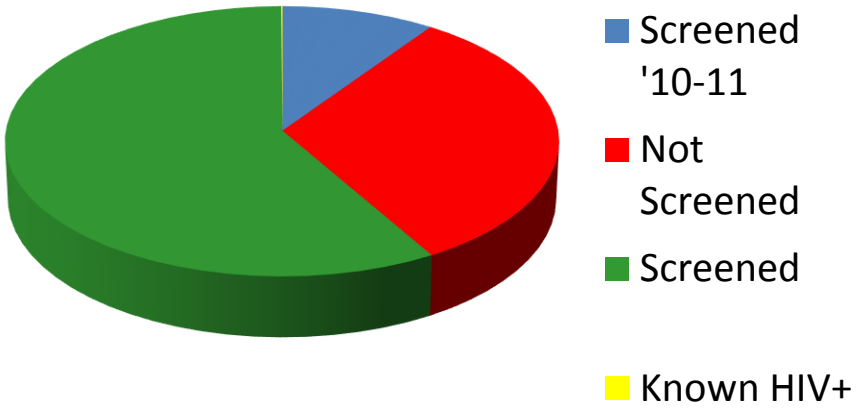


2014 ACHN

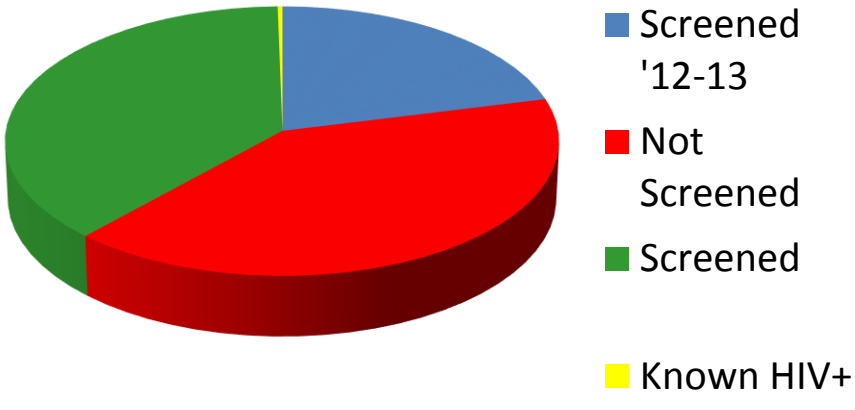


Cermak Fraction not screened ***Increased*** from 31% to 40%

2012 Cermak



2014 Cermak



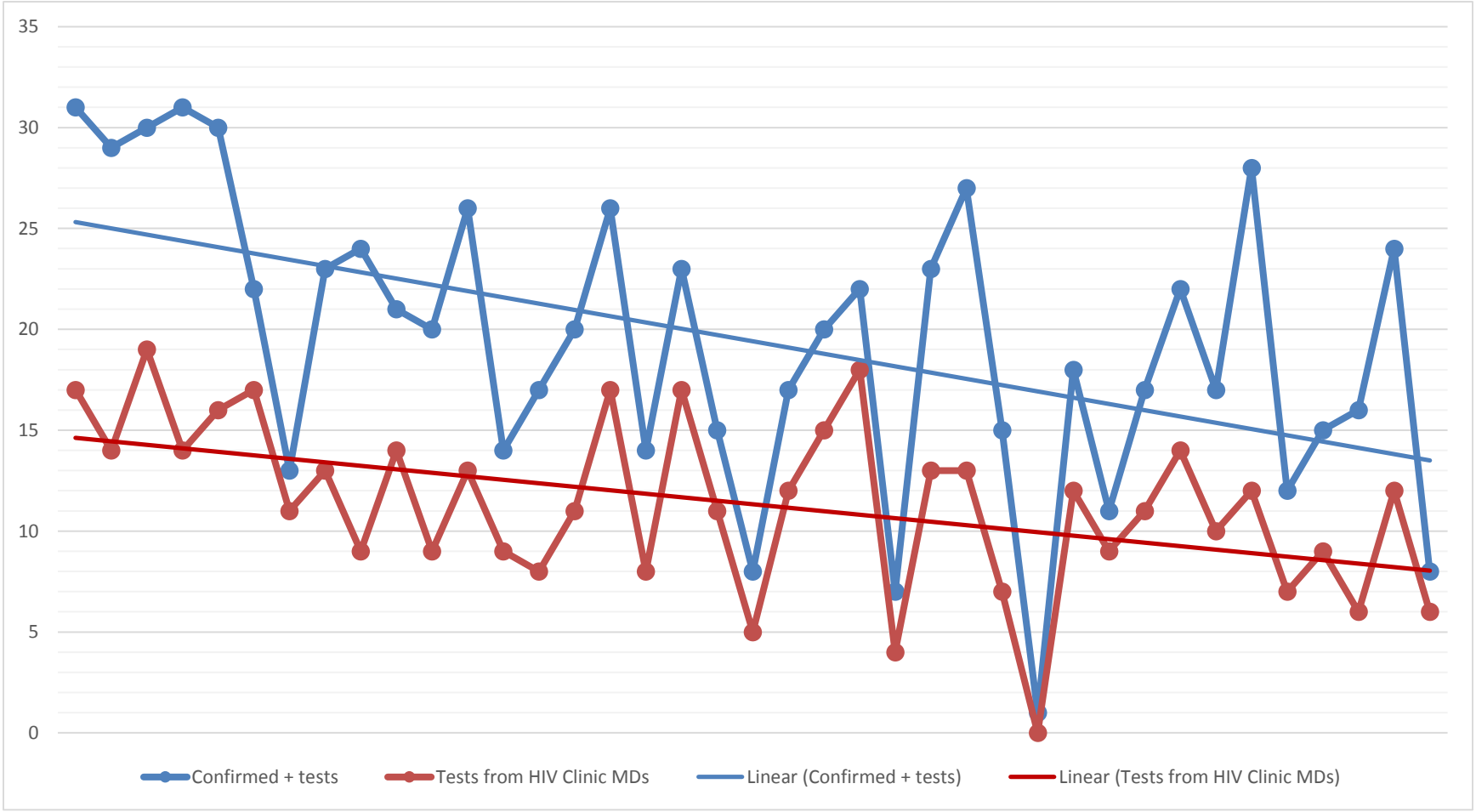
Overall HIV testing (as a proportion of patients) has increased

- Some areas (SHCC Inpatient, ACHN, SHCC ER) are benefiting from prior testing with resulting increases in overall fraction tested.
- SHCC ER, SHCC Inpt., and ACHN are increasing testing though slowly.
- Some areas that have very high HIV prevalence (PHCC ER, Cermak) are not testing at adequate frequency and their performance is worsening over time.

There is room for improvement in HIV Testing within CCHHS

- Clinical Departments should be required to set targets within their areas.
  - WHO target is 90%
  - CDC target is 100%
- Consideration should be given to tracking the fraction of patients tested down to the individual attending level for OPPE.
  - This is possible based on infrastructure built for Meaningful Use of EMR.

Past 52 weeks, #of positives and fraction that are true screening vs. confirmatory on patients referred in from outside.



Suggests we may be exhausting pool of undx'd positive patients in CCHHS

Maintaining Early Access at CORE HIV Primary Care Clinics
Time to 1st/3rd New Appointment

Service *>>> Date checked* *HIV Primary Care CORE Standard ≤10 business days*	**6/8/2014**		**6/8/20144 3rd New**		**9/16/2014**		**9/16/2014 3rd New**		**12/5/2014**		**12/5/2014 3rd New**		**3/6/2015**		**3/6/2015 3rd New**		**6/16/2015**		**6/16/2015 3rd New**	
Adult HIV Primary Care	6/17/2014	7	6/23/2014	11	9/19/2014	3	9/23/2014	4	12/12/2014	5	12/16/2014	7	3/9/2015	1	3/9/2015	1	6/17/2015	1	6/17/2015	1
Women's HIV Primary Care	6/10/2014	2	6/10/2014	2	9/24/2014	7	9/24/2014	7	12/10/2014	3	12/17/2014	8	3/18/2015	8	3/20/2015	10	6/17/2015	1	6/19/2015	3
Bilingual HIV Primary Care	6/9/2014	1	6/12/2014	4	9/18/2014	2	9/18/2014	2	12/11/2014	4	12/22/2014	11	3/9/2015	1	3/12/2015	4	6/18/2015	2	6/18/2015	2
Contimuity (Correctional) Care	6/11/2014	3	6/11/2014	3	9/17/2014	1	9/17/2014	1	12/10/2014	3	12/17/2014	8	3/11/2015	3	3/11/2015	3	6/17/2015	1	6/17/2015	1

Average waiting time for a new HIV Clinic appointment at CORE has been <1 week over past 4 quarters

Linkage to Care

- Denominator: patients who have first time confirmed HIV+ tests anywhere in CCHHS prior 3 month period
- Numerator: *of these,* patients who had a visit (not just an appointment) at a CCHHS site that provides HIV primary care
- Measure added to CORE STAR Report for 2014
- FY2014 91% had at least 1 HIV clinic visit
- First 7 mo. FY2015 = 97%
- *CORE lost 3 Outreach Workers due to CDPH realignment of Outreach programs*

Retained/Engaged in Care at CORE

- Denominator: all patients who have any visit at CORE in prior 12 months
- Numerator: *of these,* patients who had ≥2 visits at CORE >90 days apart (HRSA Defined)
  - Measure added to CORE STAR Report for 2014
- For FY2014 77% of patients were retained/engaged
- For first 7 mo. Of FY2015 = 78%

Virologic Suppression Among those Engaged in Care

- Denominator: all viral load (VL) measurements at CORE during prior month from Engaged/Retained patients
- Numerator: proportion of all VL that show reasonable virologic control
- Corresponds to cascade measure, but may underestimate success in patient getting labs but skipping visits
- FY2014 86% of engaged pts. Suppressed
- First 7 mo. of FY2015 87% are suppressed

Virologic Suppression Community Viral Load

- Denominator: ***all*** viral load (VL) measurements at CORE during prior month
- Numerator: proportion of all VL that show reasonable virologic control
- Crude but powerful overall measure of treatment efficacy (of those coming to care)
- FY2014 CVL suppression 86%
- First 7 mo. Of FY2015 = 88%

Provider summaries

- 25 measures of process and outcome
- Assesses all patients who have PCP relationship with that provider
- Given to each provider ~semi-annually
  - With comparison column for similar providers
  - With comparison column for all CORE providers
- Includes some Primary care measures –

  e.g. HgBA1C

2014 CORE Performance Measures

2014 Performance Measures	num	denom	%
Retention	3434	4328	79.3%
Two Primary Care Visits>= 3mos Apart %	3434	4328	79.3%
Percentage with>=2 CD4 Counts %	3024	4329	69.9%
Percentage with>=2 Viral Load Counts %	3056	4329	70.6%
Viral Load Suppression (<1000 copies/mL) %	3517	3829	91.9%
Viral Load Suppression (<200 copies/mL) %	3362	3829	87.8%
Viral Load Monitoring (test performed at least every 6 mos) %	2178	3553	61.3%
Cervical Cancer Screening within last 12mos %	383	1144	33.5%
Cervical Cancer Screening within last 18mos %	494	1144	43.2%
Cervical Cancer Screening within last 24mos %	608	1144	53.1%
Hepatitis B Screening %	4296	4382	98.0%
Hepatitis C Screening %	4293	4388	97.8%
Lipid Screening %	3020	4245	71.1%
Syphilis Screening (general population >=1 visit) %	3608	4363	82.7%
Syphilis Screening (engaged population >=2 visits at 6mos apart) %	2430	2776	87.5%
Chlamydia Screening w/a prior STI positive screening within last 12 mos %	637	854	74.6%
Chlamydia Screening (general population >=1 visit) %	2537	4362	58.2%
Gonorrhea Screening w/a prior STI positive screening within last 12 mos %	637	854	74.6%
Gonorrhea Screening (general population >=1 visit) %	2537	4362	58.2%
HIV+ in continuous care with a CD4 count >=200 %	2894	3434	84.3%
HIV+ in continuous care with a CD4 count >=350 %	2146	3434	62.5%
Diabetics Annual A1c %	238	301	79.1%
Diabetics Annual A1c < 9 %	190	238	79.8%
Diabetics Annual Lipids Panel %	238	301	79.1%
Diabetics Annual Lipids Panel LDL < 100 (%)	161	238	67.6%

CCHHS Wide HIV Programs

CCHHS HIV Site	SSHARC			ACHN Austin			PHCC HIV			CORE		
Performance_Measure	Num.	Denom.	%	Num.	Denom.	%	Num.	Denom.	%	Num.	Denom.	%
Two Primary Care visits>= 3mos Apart (retention)	248	303	81.85%	82	91	90.11%	361	396	91.16%	3434	4328	79.30%
Percentage with >=2 CD4 Counts	206	303	67.99%	71	91	78.02%	272	361	94.74%	3024	4329	69.90%
Percentage with >=2 Viral Load Counts	207	303	68.32%	75	91	82.42%	343	361	95.01%	3056	4329	70.60%
Viral load suppression (<1000)	212	237	89.45%	72	81	88.89%	351	361	97.23%	3517	3829	91.90%
Viral load suppression (< 200)	205	237	86.50%	72	81	88.89%	347	361	96.12%	3362	3829	87.80%
Viral load monitoring every 6 months	135	256	52.73%	51	80	63.75%	273	361	75.62%	2178	3553	61.30%
Cervical Cancer Screening within last 12 mos.	22	60	36.67%	13	21	61.90%	55	80	68.75%	383	1144	33.50%
Cervical Cancer Screening within last 18 mos.	26	60	43.33%	15	21	71.43%				494	1144	43.20%
Cervical Cancer Screening within last 24 mos.	32	60	53.33%	16	21	76.19%				608	1144	53.10%
Cervical Cancer Screening within last 36 mos.	33	55	60.00%	17	21	80.95%						
Hepatitis B Screening	219	235	93.19%	79	87	90.80%				4296	4382	98.00%
Hepatitis C Screening	331	340	97.35%	98	105	93.33%	347	361	96.00%	4293	4388	97.80%
Lipid Screening	250	319	78.37%	74	98	75.51%	308	361	85.31%	3020	4245	71.10%
Syphilis screening	169	339	49.85%	86	105	81.90%	323	361	89.50%	2430	2776	87.50%
Chlamydia Screening	101	121	83.47%	32	42	76.19%	245	361	67.86%	637	854	74.60%
Gonorrhea Screening	101	121	83.47%	32	42	76.19%	245	361	67.86%	637	854	74.60%
HIV+ in continuous care with a CD4 count >=350	239	239	100.00%	70	70	100.00%	253	361	70.01%	2146	3434	62.50%
HIV+ in continuous care with a CD4 count >=200	239	239	100.00%	70	70	100.00%	315	361	87.26%	2894	3434	84.30%
Diabetics Annual A1c	9	14	64.29%	-	-	-				238	301	79.10%
Diabetics Annual A1c < 9	6	14	42.86%	-	-	-				190	238	79.80%
Diabetics Annual Lipids	9	14	64.29%	-	-	-				238	301	79.10%
Diabetics Annual Lipids LDL < 100	4	14	28.57%	-	-	-				161	238	67.60%

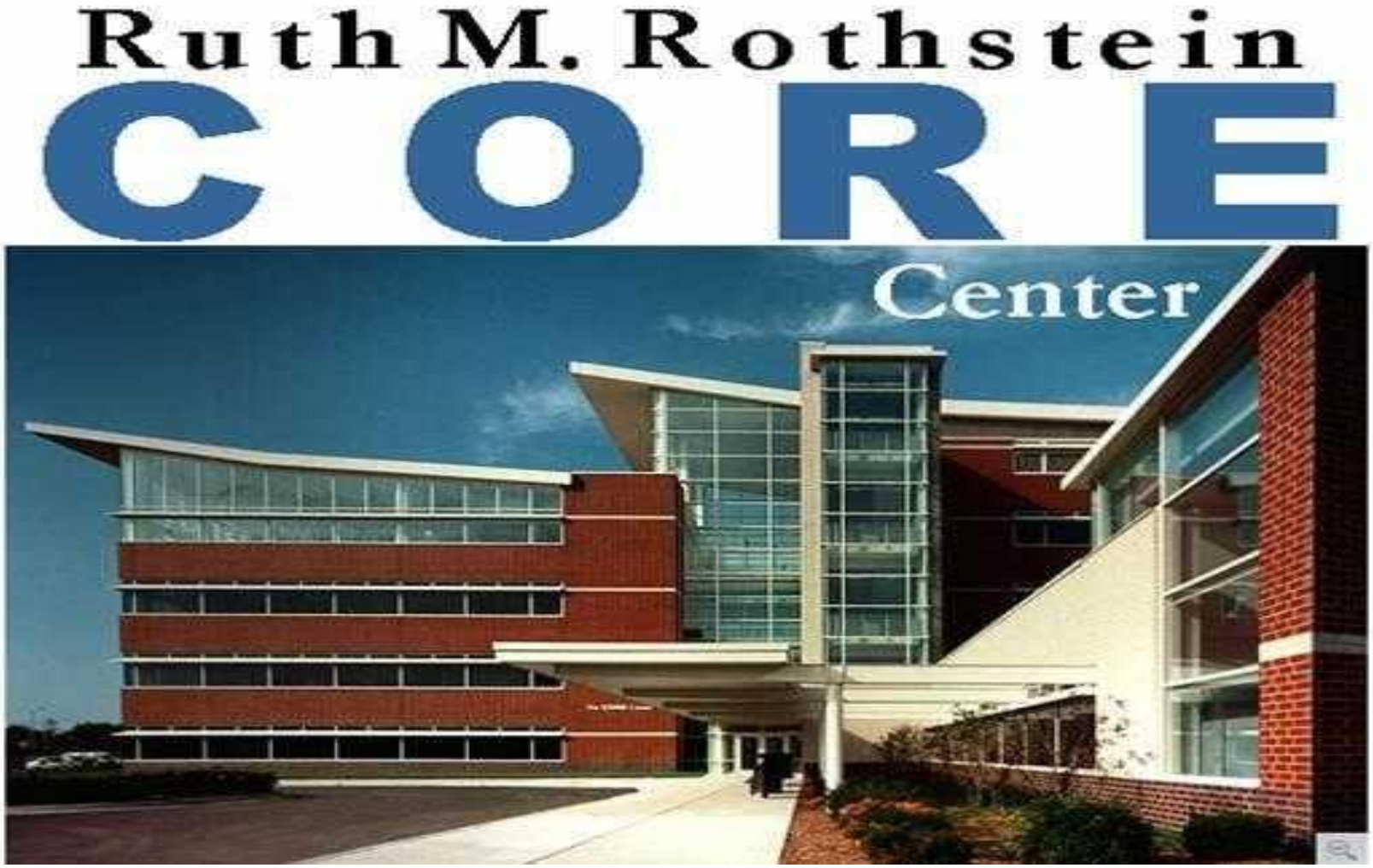
Sample Provider Summary

	Dr. XXXX			MDs			ALL CORE		
2014 Performance Measures	num	denom	%	num	denom	%	num	denom	%
Retention	**93**	**100**	**93%**	**2063**	**2746**	**75%**	**3434**	**4328**	**79%**
Two Primary Care Visits>= 3mos Apart %	110	123	89%	2382	3055	78%	3434	4328	79%
Percentage with>=2 CD4 Counts %	101	123	82%	2083	3055	68%	3024	4329	70%
Percentage with>=2 Viral Load Counts %	98	123	80%	2110	3055	69%	3056	4329	71%
Viral Load Suppression (<1000 copies/mL) %	97	110	88%	2227	2429	92%	3517	3829	92%
Viral Load Suppression (<200 copies/mL) %	95	110	86%	2133	2429	88%	3362	3829	88%
Viral Load Monitoring (test performed at least every 6 mos) %	68	113	60%	1478	2483	60%	2178	3553	61%
Cervical Cancer Screening within last 12mos %	0	5	0%	225	758	30%	383	1144	33%
Cervical Cancer Screening within last 18mos %	1	5	20%	282	758	37%	494	1144	43%
Cervical Cancer Screening within last 24mos %	5	5	100%	339	758	45%	608	1144	53%
Hepatitis B Screening %	125	130	96%	3117	3251	96%	4296	4382	98%
Hepatitis C Screening %	125	130	96%	3138	3281	96%	4293	4388	98%
Lipid Screening %	99	125	79%	2151	3056	70%	3020	4245	71%
Syphilis Screening (general population >=1 visit) %	118	129	91%	2760	3265	85%	3608	4363	83%
Syphilis Screening (engaged population >=2 visits at 6mos apart) %	76	81	94%	1717	1922	89%	2430	2776	88%
Chlamydia Screening w/a prior STI positive screening within last 12 mos %	31	38	82%	657	923	71%	637	854	75%
Chlamydia Screening (general population >=1 visit) %	83	129	64%	1961	3265	60%	2537	4362	58%
Gonorrhea Screening w/a prior STI positive screening within last 12 mos %	31	38	82%	657	923	71%	637	854	75%
Gonorrhea Screening (general population >=1 visit) %	83	129	64%	1961	3265	60%	2537	4362	58%
HIV+ in continuous care with a CD4 count >=200 %	95	110	86%	1950	2382	82%	2894	3434	84%
HIV+ in continuous care with a CD4 count >=350 %	67	110	61%	1442	2382	61%	2146	3434	62%
Diabetics Annual A1c %	7	10	70%	154	199	77%	238	301	79%
Diabetics Annual A1c < 9 %	6	7	86%	126	154	82%	190	238	80%
Diabetics Annual Lipids Panel %	9	10	90%	155	199	78%	238	301	79%
Diabetics Annual Lipids Panel LDL < 100 (%)	6	9	67%	114	155	74%	161	238	68%

Pre-Exposure Prophylaxis - PrEP

- Giving a combination of two HIV medicines to persons at high risk to *prevent* HIV infection
  - Effective at preventing infection if med taken every day
  - Risk of developing resistance if becomes infected
  - Low risk of drug toxicity – but requires lab tests
- CDC Recommendations for PrEP in May 2014
- Is not Cost-Effective
  - Limited budget for HIV meds – CORE / CCHHS will not bear cost of meds – MAP or Insurance
- CORE opened PrEP clinic in April 2015
  - Serving 40-50 patients mostly high risk MSM

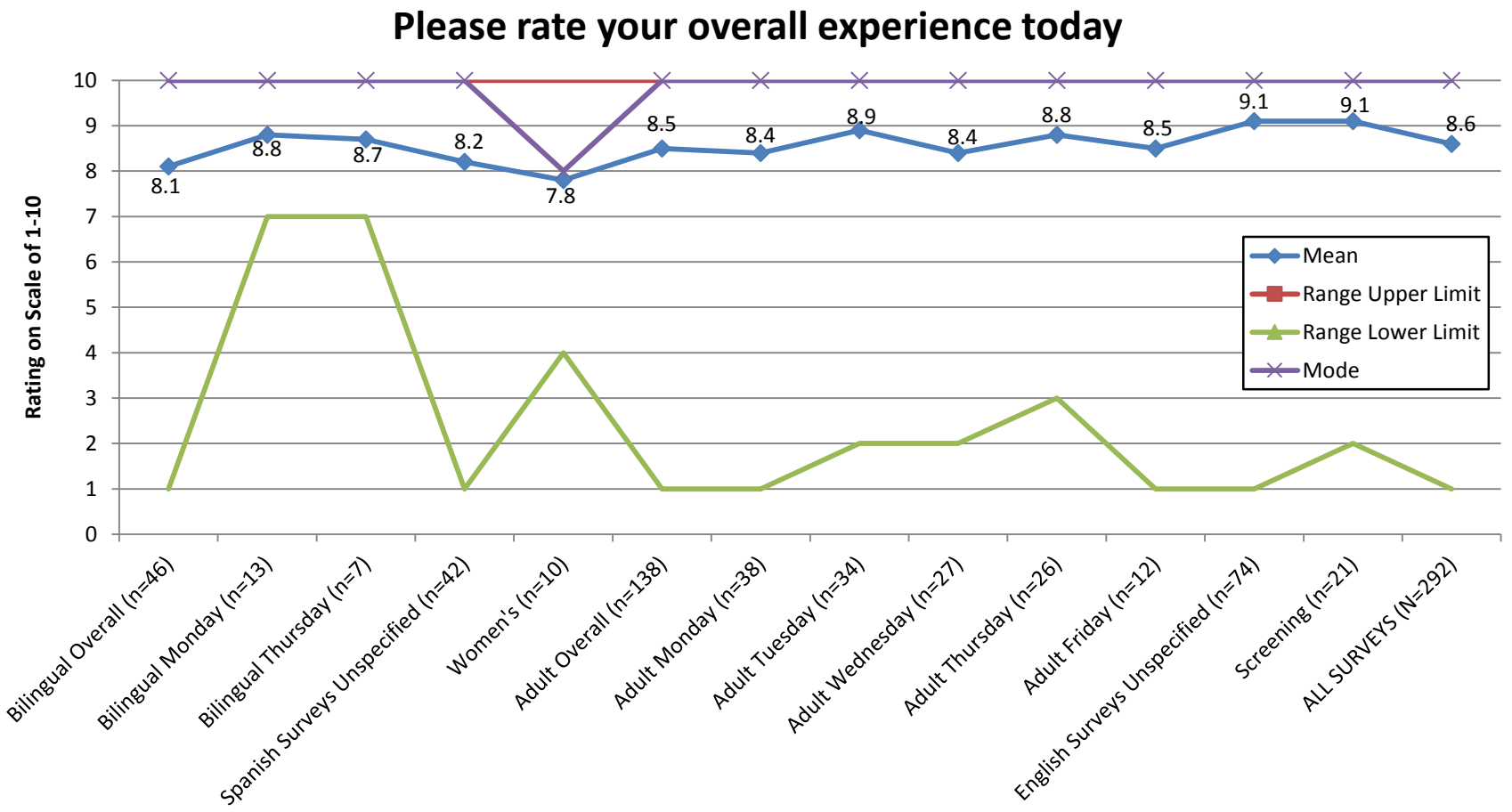
Thank you



Thanks to our patients for being surveyed, CCHHS providers for testing, Stephon Effinger, Jennifer Catrambone, Art Moswin, for data; and Chet Kelly for data and a thoughtful review.

Exit Survey 2015

n = 292



Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
July 21, 2015

ATTACHMENT #3

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Illinois Surgical Quality Improvement Collaborative (ISQIC)

Mark A Wille, MD, FACS
Attending Physician (Urology),
Department of Surgery
CCHHS Surgeon Champion

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

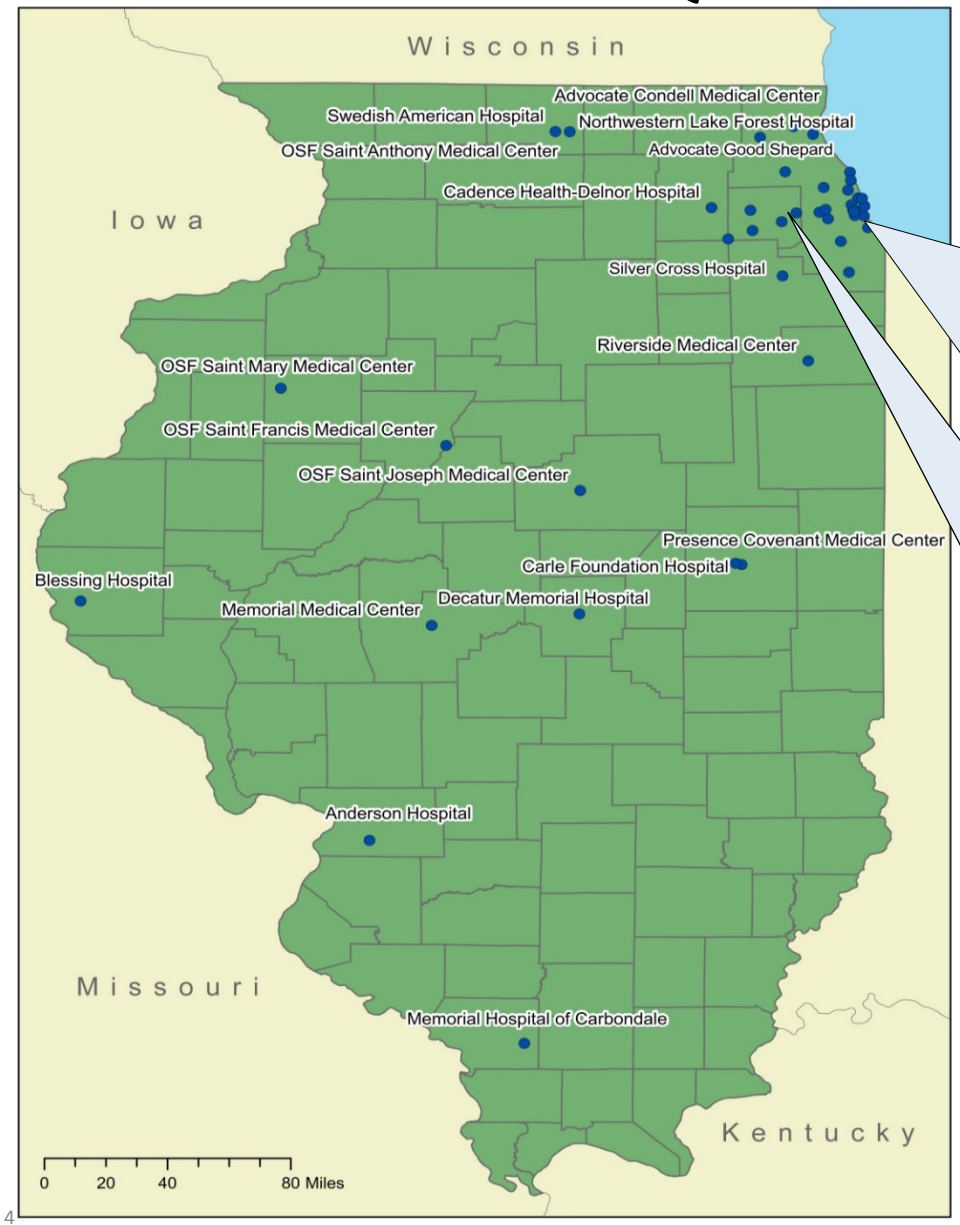
Illinois Surgical Quality Improvement Collaborative (ISQIC)

- Collaborative comprised of:
  - 54 Illinois hospitals
  - The Illinois and Metropolitan Chicago Chapters of the American College of Surgeons
  - The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP)
  - The Surgical Outcomes and Quality Improvement Center (SOQIC)
  - Blue Cross Blue Shield of Illinois

ISQIC Objective

To obtain rapid, meaningful, and sustained improvement in surgical quality by facilitating engagement in mentored, targeted Quality improvement/ Process Improvement initiatives

54 ISQIC Hospitals



Cook County Hospitals

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate South Suburban Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago
John H. Stroger Jr. Hospital of Cook County
Loyola University Health System
MacNeal Hospital
Mercy Hospital and Medical Center
Mount Sinai Hospital
NorthShore University HealthSystem (Evanston)
Northwest Community Hospital
Northwestern Memorial Hospital
Presence Resurrection Medical Center
Presence Saint Francis Hospital
Presence Saint Joseph Hospital
Presence Saint Mary and Elizabeth Medical Center
Rush Oak Park Hospital
Rush University Medical Center
Swedish Covenant Hospital
University of Chicago Medical Center
University of IL Hospital & Health Sciences System

DuPage County Hospitals

Edward Hospital
Advocate Good Samaritan Hospital
Cadence Health-Central DuPage Hospital
Rush-Copley Medical Center
Elmhurst Memorial Hospital

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Responsibilities of CCHHS (Required for Funding)

- Implement American College of Surgeons National Surgical Quality Improvement Collaborative (ACS NSQIP)
- Participate in ISQIC Quality & Process Improvement Curriculum
- Participate in annual Collaborative Quality Improvement Project (CQIP)
- Attend semi-annual conferences
- Use ISQIC data to undertake two quality improvement projects
- Present ISQIC/NSQIP data to Hospital Board on an annual basis
- Demonstrate significant improvement in at least one area (outcome or process measure) by the end of year 3

Our Hospital ISQIC Team

- Surgeon Champion: Mark A. Wille, MD, FACS
- Surgical Clinical Reviewer: Blessy Varghese, MSN, RN, CNOR
- QI Designee: Krishna Das, MD

ISQIC Overview

- We report detailed data on surgical cases and outcomes
- We receive comparative reports for our hospital
- Unique approaches to facilitate improvement
- Funding to cover participation costs

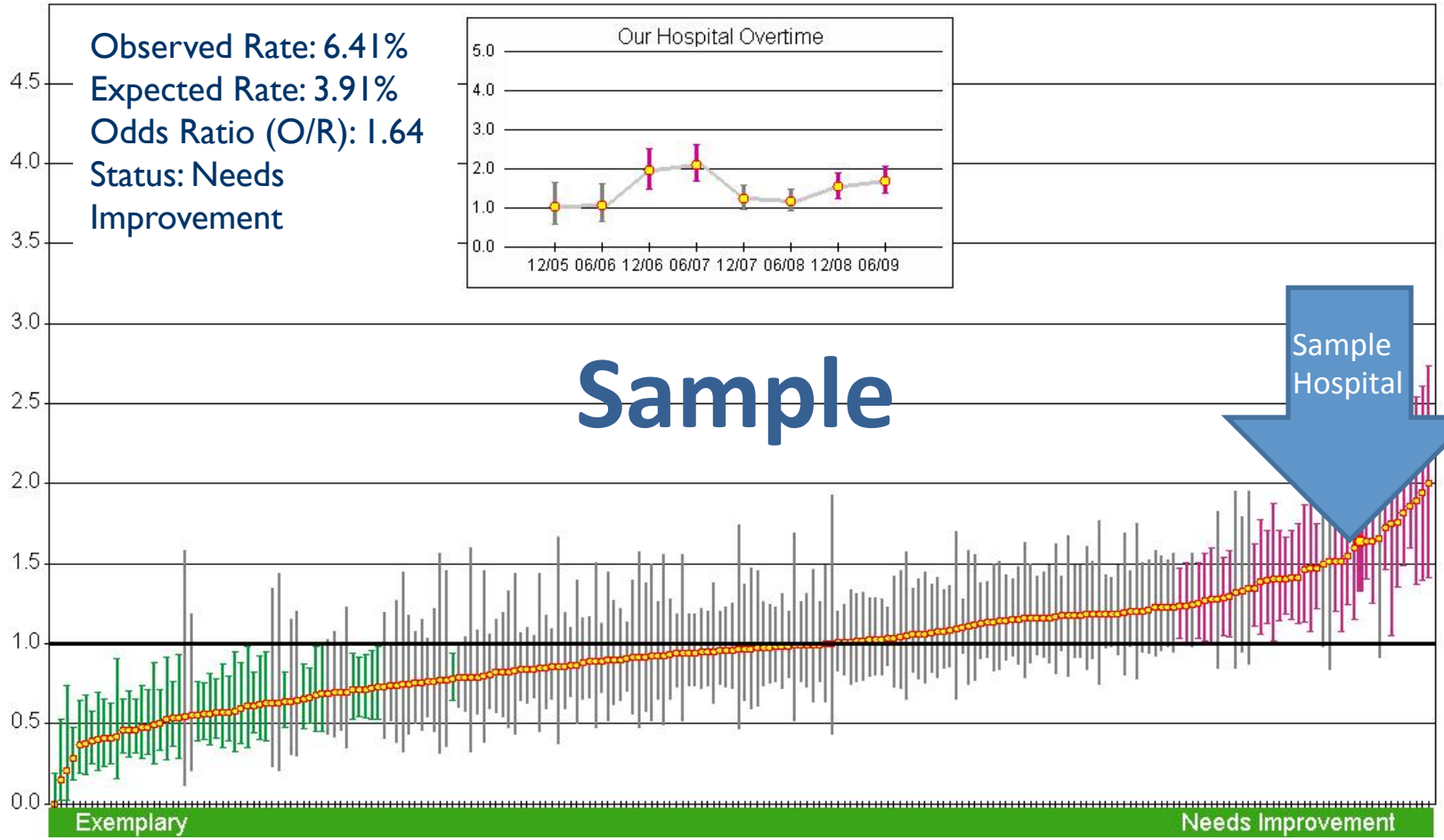
ISQIC Illinois Surgical Quality Improvement Collaborative

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

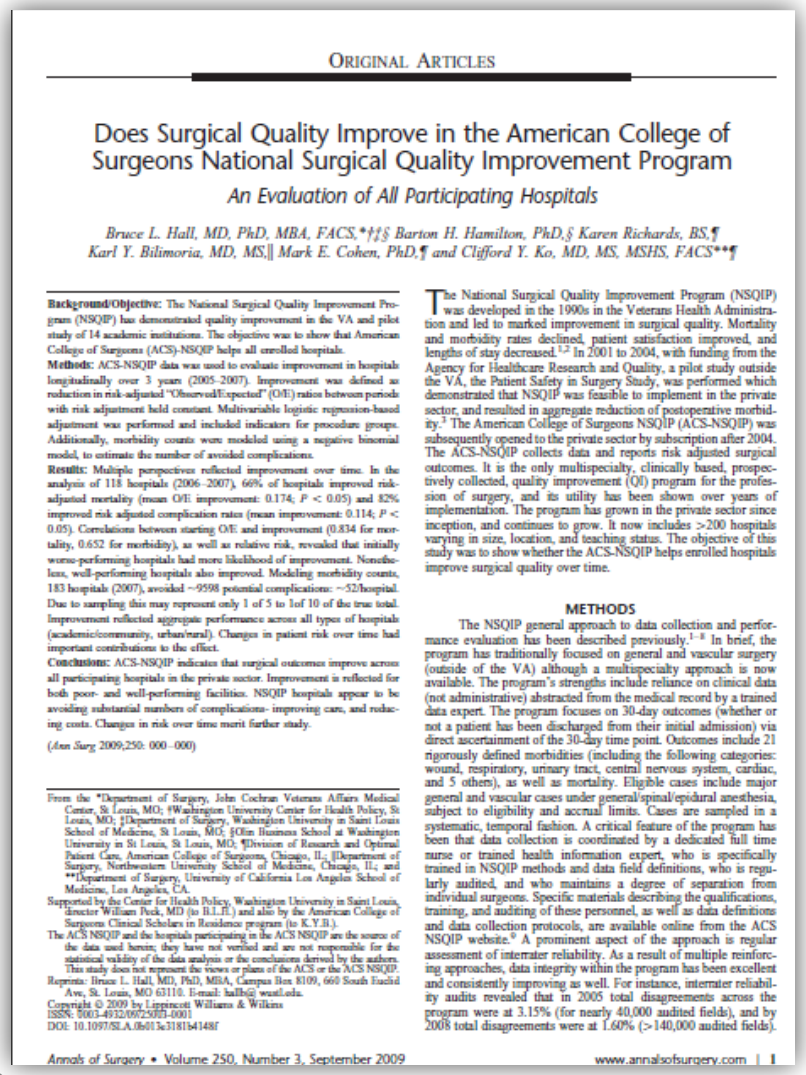
ACS NSQIP Key Features

- Rigorous clinical data abstraction
  - Standardized data definitions
  - Abstract maximum of 40 cases per week (approximately 20% of surgical volume)
  - Trained data abstractor-Surgical Clinical Reviewer (SCR)
  - Comprehensive set of >70 risk factors
  - Intraoperative Data and Postoperative Outcomes
  - Externally audited data
  - Allows for rigorous risk adjustment
- All surgical subspecialties analyzed
- Risk-Adjusted Outcomes
  - 30-day morbidity, mortality, readmission & length of stay
  - 30+ Outcomes

Comparative Reports



ACS NSQIP Works



ORIGINAL ARTICLES

Does Surgical Quality Improve in the American College of Surgeons National Surgical Quality Improvement Program

An Evaluation of All Participating Hospitals

Bruce L. Hall, MD, PhD, MBA, FACS,†‡§ Barton H. Hamilton, PhD,§ Karen Richards, BS,¶ Karl Y. Bilimoria, MD, MS,‖ Mark E. Cohen, PhD,¶ and Clifford Y. Ko, MD, MS, MSHS, FACS**¶*

Background/Objective: The National Surgical Quality Improvement Program (NSQIP) has demonstrated quality improvement in the VA and pilot study of 14 academic institutions. The objective was to show that American College of Surgeons (ACS)-NSQIP helps all enrolled hospitals.

Methods: ACS-NSQIP data was used to evaluate improvement in hospitals longitudinally over 3 years (2005–2007). Improvement was defined as reduction in risk-adjusted "Observed/Expected" (O/E) ratios between periods with risk adjustment held constant. Multivariable logistic regression-based adjustment was performed and included indicators for procedure groups. Additionally, morbidity counts were modeled using a negative binomial model, to estimate the number of avoided complications.

Results: Multiple perspectives reflected improvement over time. In the analysis of 118 hospitals (2006–2007), 66% of hospitals improved risk-adjusted mortality (mean O/E improvement: 0.174; $P < 0.05$) and 82% improved risk adjusted complication rates (mean improvement: 0.114; $P < 0.05$). Correlations between starting O/E and improvement (0.834 for mortality, 0.652 for morbidity), as well as relative risk, revealed that initially worse-performing hospitals had more likelihood of improvement. Nonetheless, well-performing hospitals also improved. Modeling morbidity counts, 183 hospitals (2007), avoided ~9598 potential complications: ~52/hospital. Due to sampling this may represent only 1 of 5 to 1of 10 of the true total. Improvement reflected aggregate performance across all types of hospitals (academic/community, urban/rural). Changes in patient risk over time had important contributions to the effect.

Conclusions: ACS-NSQIP indicates that surgical outcomes improve across all participating hospitals in the private sector. Improvement is reflected for both poor- and well-performing facilities. NSQIP hospitals appear to be avoiding substantial numbers of complications- improving care, and reducing costs. Changes in risk over time merit further study.

(*Ann Surg* 2009;250: 000–000)

From the *Department of Surgery, John Cochran Veterans Affairs Medical Center, St Louis, MO; †Washington University Center for Health Policy, St Louis, MO; ‡Department of Surgery, Washington University in Saint Louis School of Medicine, St Louis, MO; §Olin Business School at Washington University in St Louis, St Louis, MO; ¶Division of Research and Optimal Patient Care, American College of Surgeons, Chicago, IL; ‖Department of Surgery, Northwestern University School of Medicine, Chicago, IL; and **Department of Surgery, University of California Los Angeles School of Medicine, Los Angeles, CA.

Supported by the Center for Health Policy, Washington University in Saint Louis, director William Peck, MD (to B.L.H.) and also by the American College of Surgeons Clinical Scholars in Residence program (to K.Y.B.).

The ACS NSQIP and the hospitals participating in the ACS NSQIP are the source of the data used herein; they have not verified and are not responsible for the statistical validity of the data analysis or the conclusions derived by the authors. This study does not represent the views or plans of the ACS or the ACS NSQIP.

Reprints: Bruce L. Hall, MD, PhD, MBA, Campus Box 8109, 660 South Euclid Ave, St. Louis, MO 63110. E-mail: hallb@wustl.edu.

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The National Surgical Quality Improvement Program (NSQIP) was developed in the 1990s in the Veterans Health Administration and led to marked improvement in surgical quality. Mortality and morbidity rates declined, patient satisfaction improved, and lengths of stay decreased.[1,2] In 2001 to 2004, with funding from the Agency for Healthcare Research and Quality, a pilot study outside the VA, the Patient Safety in Surgery Study, was performed which demonstrated that NSQIP was feasible to implement in the private sector, and resulted in aggregate reduction of postoperative morbidity.[3] The American College of Surgeons NSQIP (ACS-NSQIP) was subsequently opened to the private sector by subscription after 2004. The ACS-NSQIP collects data and reports risk adjusted surgical outcomes. It is the only multispecialty, clinically based, prospectively collected, quality improvement (QI) program for the profession of surgery, and its utility has been shown over years of implementation. The program has grown in the private sector since inception, and continues to grow. It now includes >200 hospitals varying in size, location, and teaching status. The objective of this study was to show whether the ACS-NSQIP helps enrolled hospitals improve surgical quality over time.

METHODS

The NSQIP general approach to data collection and performance evaluation has been described previously.[1–8] In brief, the program has traditionally focused on general and vascular surgery (outside of the VA) although a multispecialty approach is now available. The program's strengths include reliance on clinical data (not administrative) abstracted from the medical record by a trained data expert. The program focuses on 30-day outcomes (whether or not a patient has been discharged from their initial admission) via direct ascertainment of the 30-day time point. Outcomes include 21 rigorously defined morbidities (including the following categories: wound, respiratory, urinary tract, central nervous system, cardiac, and 5 others), as well as mortality. Eligible cases include major general and vascular cases under general/spinal/epidural anesthesia, subject to eligibility and accrual limits. Cases are sampled in a systematic, temporal fashion. A critical feature of the program has been that data collection is coordinated by a dedicated full time nurse or trained health information expert, who is specifically trained in NSQIP methods and data field definitions, who is regularly audited, and who maintains a degree of separation from individual surgeons. Specific materials describing the qualifications, training, and auditing of these personnel, as well as data definitions and data collection protocols, are available online from the ACS NSQIP website.[9] A prominent aspect of the approach is regular assessment of interrater reliability. As a result of multiple reinforcing approaches, data integrity within the program has been excellent and consistently improving as well. For instance, interrater reliability audits revealed that in 2005 total disagreements across the program were at 3.15% (for nearly 40,000 audited fields), and by 2008 total disagreements were at 1.60% (>140,000 audited fields).

82%

OF HOSPITALS DECREASED COMPLICATIONS

66%

OF HOSPITALS DECREASED MORTALITY

POOR PERFORMERS AND TOP PERFORMERS IMPROVED

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

Cost Savings/ Return on Investment

Through participation in ACS NSQIP

- An average hospital can prevent approximately 250 complications per year
  - Cost of complication: $10,000
  - Potential savings per hospital: $2,500,000

- Examples of real savings include ACS NSQIP hospitals that have reduced costs by $2M-2.5M.

Successful Surgical Quality Collaboratives

Michigan Surgical Quality Collaborative (MSQC)

Reduction in statewide complication rates

Sepsis	↓34%
Septic shock	↓37%
Pneumonia	↓29%
Prolonged ventilation	↓22%
SSI	↓13%
Cardiac arrest	↓33%

ISQIC Resources to Facilitate Improvement

- Formal quality and process improvement curriculum
- Surgeon Mentor
- Process improvement coach
- Customized, Illinois-specific benchmark reports
- Statewide collaborative QI projects
- Pilot grants
- Semi-annual meeting

Funding

- CCHHS participation in ISQIC is underwritten by funding from Blue Cross and Blue Shield of Illinois.
  - Covers
    - Data abstractor / project manager
    - Collaborative participation
    - ACS NSQIP annual fee
- The Surgeon Champion's participation in the ISQIC is underwritten by funding from the Surgical Outcomes and Quality Improvement Center of Northwestern University.

Anticipated Return on Investment for ISQIC Hospitals

- 30% reduction in complications & death
- 25% fewer readmissions and reduced length of stay
- Savings of $1-2 million per hospital

What have we accomplished?

- Assembled our team
- Completed necessary training
- Abstracted >750 Cases as of 7/17/2015
- Streamlined our abstraction process
- Engaged in partnership with surgeon mentor
- Started data gathering for Illinois-wide project on Venous Thromboembolism
- Participating in 2015 Annual Meeting
- Eagerly anticipating our first Semi-annual report

Thank you

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

ATTACHMENT #4

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Toni Preckwinkle
President
Cook County Board of Commissioners

John Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals System

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

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Dorene P. Wiese, EdD

Ozuru O. Ukoha, MD
President,
Executive Medical Staff
John H. Stroger, Jr.
Hospital of Cook County

Date: July 15, 2015

Dear members of the Quality and Patient Safety Committee of the CCHHS Board:

Please be advised that the Executive Medical Staff Committee of John H. Stroger, Jr. Hospital of Cook County, at its July 14, 2015 meeting, approved the attached list of medical staff action items for your consideration.

Respectfully,

Ozuru O. Ukoha, MD
President, EMS

John H. Stroger, Jr. Hospital of Cook County

Medical Staff and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Achankunju, Jyothi, MD Appointment Effective:	Medicine/General Medicine July 21, 2015 thru July 20, 2017	Active Physician
Batra, Kumar, MD Appointment Effective:	Medicine/Hematology-Oncology July 21, 2015 thru July 20, 2017	Active Physician
Choi, Daniel, MD Appointment Effective:	Pediatrics/Hematology-Oncology July 21, 2015 thru July 20, 2017	Voluntary Physician
Dhanireddy, Bharat, MD Appointment Effective:	Medicine/Hospital Medicine July 21, 2015 thru July 20, 2017	Active Physician
Gbotosho, Ayodejia, MD Appointment Effective:	Family Medicine July 21, 2015 thru July 20, 2017	Active Physician
Gitelis, Steven, MD Appointment Effective:	Surgery/Orthopaedic July 21, 2015 thru July 20, 2017	Voluntary Physician
Jiang, Emily, MD Appointment Effective:	Correctional Health Services/Family Medicine July 21, 2015 thru July 20, 2017	Active Physician
Mittal, Shruti, MD Appointment Effective:	Pediatrics/Chief Resident July 21, 2015 thru July 20, 2017	Active Physician
Morales-Estrella, Jorge, MD Appointment Effective:	Medicine/Hospital Medicine July 21, 2015 thru July 20, 2017	Voluntary Physician
Qureshi, Javeria S. MD Appointment Effective:	Surgery/General Surgery July 21, 2015 thru July 20, 2017	Affiliate Physician
Rossini, Connie J., MD Appointment Effective:	Surgery/Pediatric Surgery July 21, 2015 thru July 20, 2017	Voluntary Physician
Santhiraj, Yaveen, MD Appointment Effective:	Medicine/Hospital Medicine July 21, 2015 thru July 20, 2017	Active Physician
Schmukler, Juan, MD Appointment Effective:	Medicine/Hospital Medicine July 21, 2015 thru July 20, 2017	Voluntary Physician
Sheng, Neha, MD Appointment Effective:	Surgery/Vascular Surgery July 21, 2015 thru July 20, 2017	Active Physician
Shivakumar, Vidya, MD Appointment Effective:	Medicine/Dermatology July 21, 2015 thru July 20, 2017	Active Physician
Subramanian, Rakesh, MD Appointment Effective:	Medicine/Hospital Medicine July 21, 2015 thru July 20, 2017	Voluntary Physician
Tylka, Joanna, MD Appointment Effective:	Pediatrics/Critical Care July 21, 2015 thru July 20, 2017	Voluntary Physician

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JULY 21, 2015

John H. Stroger, Jr. Hospital of Cook County (continued)

INITIAL APPOINTMENT NON-PHYSICIAN APPLICATION

Waxler, Brian, PsyD Appointment Effective:	Correctional Health Services/Psychiatry July 21, 2015 thru July 20, 2017	Clinical Psychologist
Winston, Laurean J., PA-C With Beck, Traci P., MD Alternate Vidal, Patricia., MD Effective:	Surgery/Urology July 21, 2015 thru July 20, 2017	Physician Assistant

REAPPOINTMENT APPLICATIONS

Department of Correctional Health Services:

Yu, Yan K., DO Reappointment Effective:	Family Medicine August 19, 2015 thru June 20, 2017	Active Physician

Department of Family and Community Medicine:

Auguston, Priscilla, MD Reappointment Effective:	Family Medicine August 14, 2015 thru August 13, 2017	Active Physician

Department of Medicine:

Ahmed, Azazuddin, MD Reappointment Effective:	General Medicine July 21, 2015 thru July 20, 2016	Active Physician
Bell, Angela, MD Reappointment Effective:	General Medicine August 26, 2015 thru August 25, 2017	Active Physician
Davidovich, Michael, MD Reappointment Effective:	General Medicine July 21, 2015 thru July 20, 2017	Active Physician
Fakhrn, Sherene, MD Reappointment Effective:	Pulmonary/Critical Care July 28, 2015 thru July 27, 2017	Active Physician
Gordon, Melanie, MD Reappointment Effective:	General Medicine August 9, 2015 thru August 8, 2017	Active Physician
Jung, Alan, MD Reappointment Effective:	Hospital Medicine August 14, 2015 thru August 13, 2017	Active Physician
Littleton, Stephen, MD Reappointment Effective:	Pulmonary/Critical Care July 28, 2015 thru July 27, 2017	Active Physician
Muthiah, Chethral, MD Reappointment Effective:	Infectious Diseases July 21, 2015 thru July 20, 2017	Consulting Physician
Perumal, Kalyani, MD Reappointment Effective:	Nephrology August 26, 2015 thru August 25, 2017	Active Physician
Swamy, Nagubadi, MD Reappointment Effective:	Pulmonary/Critical Care August 26, 2015 thru August 25, 2017	Active Physician

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BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JULY 21, 2015

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Obstetrics and Gynecology:

Gandia, Justin, MD Reappointment Effective:	Ob/Gyne August19, 2015 thru August 18, 2017	Affiliate Physician
Milad, Magdy, MD Reappointment Effective:	Ob/Gyne July 28, 2015 thru July 27, 2017	Voluntary Physician

Department of Pathology:

Ray, Vera, MD Reappointment Effective:	Anatomic Pathology August 19, 2015 thru August 18, 2017	Consulting Physician
Strauss, Ronald G., MD Reappointment Effective:	Blood Bank September 23, 2015 thru September 22, 2017	Active Physician
Tarjan, Gabor, MD Reappointment Effective:	Anatomic Pathology October 21, 2015 thru October 20, 2017	Active Physician

Department of Pediatrics:

Kuppy, Joanna, MD Reappointment Effective:	Critical Care August 26, 2015 thru August 25, 2017	Voluntary Physician
Watts, Tabitha, MD Reappointment Effective:	Peds Emergency August 14, 2015 thru August 13, 2017	Voluntary Physician

Department of Psychiatry:

Akinbile(Scott), Nelda F., MD Reappointment Effective:	Ped. Emergency August 19, 2015 thru August 18, 2017	Active Physician

Department of Radiology:

Sansi, Pratiba K.., MD Reappointment Effective:	Nuclear Medicine October 20, 2015 thru October 19, 2017	Voluntary Physician

Department of Surgery:

Harrison, Jacqueline L., MD Reappointment Effective:	General Surgery July 21, 2015 thru July 20, 2017	Active Physician
Komar, Thomas M., MD Reappointment Effective:	General Surgery July 21, 2015 thru July 20, 2017	Active Physician
Merk, Bradley R., MD Reappointment Effective:	Orthopaedic August 19, 2015 thru August 18, 2017	Consulting Physician
Monahan, Denise A., MD Reappointment Effective:	Breast Oncology July 21, 2015 thru July 20, 2017	Active Physician
Sauper, Alexander J., MD Reappointment Effective:	General Surgery July 21, 2015 thru July 20, 2017	Active Physician

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ON JULY 21, 2015

John H. Stroger, Jr. Hospital of Cook County (continued)

Renewal of Privileges for Non-Medical Staff:

Eldridge, Curtis L., CCP Effective:	Surgery/Cardiothoracic August 06, 2015 thru August 05, 2017	Perfusionist
Reed-Davis, Freddie, CNP With David, Richard J., MD Effective:	Pediatrics / Neonatology July 21, 2015 thru July 20, 2017	Nurse Practitioner
Ramos, Lourdes L., CNP With Gandhi, Yogesh., MD Effective:	Surgery / Neurosurgery July 21, 2015 thru July 20, 2017	Nurse Practitioner
Strozdas, Linda J., PsyD Reappointmet Effective:	Psychiatry/Psychology August 19, 2015 thru August 18, 2017	Clinical Psychologist
Uzomba, Adaku N., CNS With Kelly, Michael A., MD Effective:	Medicine/Neurology July 21, 2015 thru July 20, 2017	Clinical Nurse Specialist
Yurasek, Frank, PhD Effective:	Anesthesiology/Pain Management August 26, 2015 thru August 25, 2017	Acupuncturist
Zien, Joel W., PA-C With Gandhi, Yogesh, MD Alternate Sierens, Diane K., MD Effective:	Surgery/Neurosurgery July 21, 2015 thru July 20, 2017	Physician Assistant

Prescriptive Authority Only:

Kurn, Maria Del Carmen P., CNP With Quesada-Rodrigues, Nancy M., MD Effective:	Medicine/Pulmonary & Critical Care July 21, 2015 thru May 11, 2017	Nurse Practitioner

Agreement Items:

Goldstein, Deborah, CNP Effective:	Medicine/Pulmonary July 21, 2015 thru March 19, 2016	Nurse Practitioner
Sanchez, Luis M., PA-C With Bradley, Juliet L., MD Alternate Vazquez, Alicia, MD Effective:	Family Medicine/ACHN July 21, 2015 thru June 18, 2017	Physician Assistant

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BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JULY 21, 2015

Toni Preckwinkle
President
Cook County Board of Commissioners

John Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals System

COOK COUNTY HEALTH & HOSPITALS SYSTEM
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Erica E. Marsh, MD MSCI
Carmen Velasquez
Dorene P. Wiese, EdD

Anwer Hussain, DO, FAAEM
President,
Medical Executive Committee
Provident Hospital
Of Cook County

July 10, 2015

Dear Members of the Quality and Patient Safety Committee:

Please be advised that at the Credentials Meeting held on July 7, 2015 the Medical Executive Committee of Provident Hospital of Cook County recommended the actions on the enclosed list. It is being presented to you for your consideration.

Respectfully,

Anwer Hussain, DO
President, MEC

Provident Hospital of Cook County

Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Burtch, Rahda, MD, MD Appointment Effective:	Ob/Gyne July 21, 2015 thru July 20, 2017	Affiliate Physician
Qureshi, Javeria S. MD Appointment Effective:	Surgery/General Surgery July 21, 2015 thru July 20, 2017	Voluntary Physician

REAPPOINTMENT APPLICATIONS

Department of Anesthesiology:

Swiner III, Connie, MD Reappointment Effective:	Anesthesia August 8, 2015 thru August 7, 2017	Active Physician

Department of Clinical Labs and Pathology:

Ray, Vera, MD Reappointment Effective:	Clinical Laboratory September 23, 2015 thru September 22, 2017	Voluntary Physician
Strauss, Ronald G., MD Reappointment Effective:	Clinical Laboratory September 20, 2015 thru September 19, 2017	Affiliate Physician

Department of Family Medicine:

Cash, Crystal, MD Reappointment Effective:	Family Medicine August 1, 2015 thru July 31, 2017	Active Physician
Tinfang, Chantal Sylvie M., MD Reappointment Effective:	Family Medicine August 19, 2015 thru August 18, 2017	Active Physician

Department of Internal Medicine:

Clapp, William, MD Reappointment Effective:	Pulmonary Medicine July 21, 2015 thru March 17, 2017	Affiliate Physician
Clarke, Clifton B., MD Reappointment Effective:	Pulmonary Medicine August 1, 2015 thru July 31, 2017	Active Physician

Department of Surgery:

Harrison, Jacqueline L., MD Reappointment Effective:	General Surgery July 21, 2015 thru July 20, 2017	Affiliate Physician
Sauper, Alexander J., MD Reappointment Effective:	General Surgery July 21, 2015 thru July 20, 2017	Affiliate Physician

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JULY 21, 2015